MEDICARE AND MEDICAID FRAUDS

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HEARING

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 2—WASHINGTON, D.C.

NOVEMBER 13, 1975

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Medicare and Medicaid Frauds:

Part 1. Washington, D.C., September 26, 1975.
Part 2. Washington, D.C., November 13, 1975.
Part 3. Washington, D.C., December 5, 1975.
Part 4. Washington, D.C., February 16, 1976.

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MEDICARE AND MEDICAID FRAUDS

THURSDAY, NOVEMBER 13, 1975

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE
OF THE SPECIAL COMMITTEE ON AGING
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 235, Russell Building, Hon. Frank E. Moss, chairman, presiding.

Present: Senators Moss, Clark, Percy, and Brock.

Also present: Val J. Halamandaris, associate counsel; John Guy Miller, minority staff director; Margaret Fayé, minority professional staff member; William Halamandaris, William Recktenwald, and David Holton, investigators; Patricia G. Oriol, chief clerk; and Dona Daniel, clerk.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. The hearing will come to order.

Good morning, and welcome to this hearing by the Subcommittee on Long-Term Care. This hearing continues our inquiry into the dimensions of medicare and medicaid fraud.

On September 26 we heard from several witnesses who estimated that as much as $3 billion out of medicare and medicaid's $30 billion total may be made up of fraudulent or at least questionable payments. In the clinical lab area, the executive director of the Illinois Clinical Laboratory Association estimated that one out of every six medicaid dollars in lab fees is ripped off by the unscrupulous.

At this same hearing we learned a little of the operations of two hospitals that specialize in welfare patients. We learned of the operations of factoring companies and how delay and inefficiency by State government multiplies their profits.

On October 28 we learned about the operations of some for-profit home health and homemaker service agencies.

We intend to followup on all of these leads with subsequent hearings. I want it understood that my idea for cutting Government spending and moving toward a balanced budget is to eliminate inefficiency, fraud, and abuse in Government health care problems, particularly medicaid.

We have several witnesses today so I will not take any more time, except to say that I am anxious to hear the testimony of the U.S. General Accounting Office. We rely upon GAO a great deal. We are very grateful for all the assistance that they have given us. Their

appearance before us this morning stems from our examination of New York nursing homes. They have completed an audit involving nursing homes in New York and several States at our request and I welcome the results.

Before I call Mr. Ahart of the GAO, I would like to acknowledge the assistance of George Bliss, Pulitzer Prize-winning journalist with the Chicago Tribune. Mr. Bliss has been most helpful to the committee.

Our first witness then will be Mr. Gregory J. Ahart, Director of the Manpower and Welfare Division of the U.S. General Accounting Office. We are pleased to have you sir, and we'll ask you to go right ahead.

STATEMENT OF GREGORY J. AHART, DIRECTOR, MANPOWER AND WELFARE DIVISION, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY ROBERT IFFERT, ASSISTANT DIRECTOR, AND GEORGE PITTSLEY, SUPERVISORY AUDITOR

Mr. Ahart. Thank you, Mr. Chairman. I'd like to introduce my associates at the table. On my far right is Mr. Robert Iffert, an Assistant Director in the Manpower and Welfare Division. On my immediate right is Mr. George Pittsley, who has had immediate charge of the review we'll be talking about this morning. He's a supervisory auditor in the Manpower and Welfare Division.

Senator Moss. We welcome you, gentlemen, to the committee.

Mr. Ahart. We are pleased to be here today to summarize the results of our review of controls by HEW and various States over the personal funds of medicaid patients residing in nursing homes and intermediate care facilities. Such funds are maintained by the facilities on behalf of the patients.

Our review was made at the request of this subcommittee and we expect to submit our final report in the near future.

Medicaid—authorized by title XIX of the Social Security Act, as amended—is a grant-in-aid program under which the Federal Government pays part of the costs incurred by States in providing medical services to persons unable to pay for such care. The Federal Government pays from 50 to 78 percent of the costs incurred by States in providing medical services under the medicaid program. The Social Security Act requires that State medicaid programs provide skilled nursing home services. Services in intermediate care facilities, which are designed to provide care to patients that do not require skilled nursing services, are an optional medicaid service. Nationwide about 7,000 skilled nursing facilities and 7,500 intermediate care facilities are participating in medicaid.

Sources of Patient Funds

The funds we are discussing today generally involve the $25 a-month-allowance set-aside for the personal needs of medicaid patients. One source of personal funds is the Federal supplementary security income program, popularly known as SSI, which was established by title XVI of the Social Security Act. The program became

effective in January 1974 and replaced and broadened the previous federally assisted, State-administered, cash assistance programs for the aged, blind, and disabled.

Section 1611(c) of the act provided that an SSI recipient being cared for in an institution participating in medicaid will receive a reduced SSI payment of up to $25 a month—provided the recipient's other income is less than $25—which is to provide for the personal needs of the patient. In conformance with the SSI payment level, for institutionalized patients, medicaid regulations require the maintenance level for any institutionalized aged, blind, or disabled medicaid recipient must be a minimum of $25 a month. However, a State may set a higher personal needs allowance level if it so wishes. Any income above the personal needs must be applied to the cost of care in the facility which serves to reduce the amount paid by medicaid.

In addition to SSI benefits, patients' funds may come from a variety of sources, including social security benefits, veterans' benefits, disability compensation, and contributions from relatives.

Our review included work at HEW headquarters in Washington, D.C. We also visited HEW regional offices in Atlanta, Chicago, Kansas City, New York, and San Francisco; and State agency offices in California, Florida, Michigan, Missouri, and New York. In addition, we visited a total of 30 skilled nursing homes or intermediate care facilities in these 5 States. These institutions were selected on the basis of size, location within the State, and type of facility such as proprietary, private, nonprofit, and public.

During the next few minutes, I will be discussing our findings related to: The existence and adequacy of Federal and State regulations and guidelines for the handling of medicaid patients' personal funds in the custody of facilities; how selected facilities have handled patient funds; and the adequacy of the monitoring activities of the States regarding facility compliance with regulations and guidelines.

HEW and State Regulations and Guidelines

For skilled nursing homes, Federal medicaid regulations require that a patient be allowed to manage his personal financial affairs, or be given at least a quarterly accounting of financial transactions made on his behalf. For intermediate care facilities, Federal regulations require that a written account be maintained and be available to residents and their families.

We could locate little in the way of HEW interpretive instructions pertaining to such important matters as (1) how patient funds should be safeguarded and accounted for; (2) what service or items provided by the institution could be properly considered as a personal need and charged to the patient's personal funds and what service or items were to be considered as part of the regular medicaid reimbursement to the facility; or (3) how personal funds were to be disposed of upon the death or discharge of the patient.

The HEW interpretive instructions that were located included a Social and Rehabilitation Service headquarters memorandum dated July 31, 1974, to the SRS Kansas City regional office which stated

that items such as wheelchairs, walkers, and crutches should be considered part of normal skilled nursing facility services and thus should not be charged to the patient; and a State should stipulate in its agreements with facilities the items and services expected as part of routine care.

Another headquarters memorandum dated August 18, 1975, to the SRS New York Regional Office stated that a nursing home was not allowed to charge a fee for managing patients' funds and that interest earned on patient funds should accrue to the individual patients.

Each of the five States we visited had issued some instructions to nursing homes with regard to the handling of patient funds. However, these instructions varied from the rather comprehensive regulations issued by California to a booklet which Missouri provided to nursing homes that included only a section on items for which medicaid patients could not be charged.

Facilities participating in medicaid must be licensed by the State, and in California the licensing code included detailed requirements concerning the use, custody, and disposition of patients' personal funds which included the following:

1. A home could not use patients' moneys or valuables as its own or mingle them with its own.
2. A home must maintain adequate safeguards and accurate records of patients' moneys and valuables entrusted to its care.
3. All patients' moneys in excess of $500 at any facility should be deposited in a checking account.
4. Upon discharge, a patient's money should be surrendered to the patient in exchange for a signed receipt.
5. Generally, within 30 days following the death of a patient, all funds and valuables of that patient should be turned over to the person responsible for the patient in exchange for a signed receipt.
6. Upon change of ownership of a facility, a written verification by a public accountant of all patients' moneys being transferred to the custody of the new owner should be obtained by the new owner in exchange for a signed receipt.

With respect to the other four States visited, we noted that Florida, like California, required that facilities (1) not use patients' moneys nor mingle them with the facilities' own, (2) keep complete and accurate records of all funds of their patients, and (3) provide for the safekeeping of personal funds.

Michigan had regulations that (1) did not permit the mingling of patient funds, and (2) required the facility to report the amounts of deceased patients' funds to the person responsible for the patient or to the county. Michigan also required its facilities to secure bonds covering trust funds and to give a quarterly accounting of all patients' funds.

Missouri published a "Medicaid Instruction Manual" in May 1974, which was distributed to nursing facilities in the State and which specified those services not covered by the State's reimbursement rate. These noncovered services were categorized as either

personal items which could be charged to the patient or specified medical items which could be charged to third parties such as relatives. An SRS Kansas City Regional Office official advised us, however, that this section of the manual was not in compliance with Federal regulations because some of the items or services listed as noncovered medicaid items should have been covered by medicaid.

New York had regulations which spelled out the items of services that must be included in the basic rate of the facility. These services included: Board, including special diets; lodging; laundry service for personal clothing items; and the use of walkers, wheelchairs, and other supportive equipment.

Although New York had not issued any regulations directly related to the use, custody, and disposition of patient funds, the State was drafting proposals in August 1975.

How Patient Funds Have Been Handled

The 30 facilities in the 5 States we visited included proprietary, nonprofit, and public facilities. At each facility, we reviewed the procedures and practices used to manage and account for patient funds in their custody. This was done by interviewing appropriate facility officials, reviewing available accounting records, testing transactions in individual accounts, and interviewing patients.

At each of the 30 facilities we identified problems. Major problems included the following:

1. *Shortages between patient ledger balances and the bank accounts.*—The most common method used by the facilities to account for patient funds consisted of maintaining individual ledger accounts and a bank account in which patients' funds were deposited. The amount in the bank account should equal or be reconciled to the ledger balances, but at three facilities in three States, the bank accounts had less funds than the individual ledger balances showed there should have been. These shortages amounted to $445, $9,044, and $23,275. The $445 shortage was replaced by the facility's administrator soon after we brought it to his attention. The latter two shortages go back several years and are further complicated by changes in ownership. We reported the other shortages to State or Federal officials.

2. *Charging patients for medical supplies and services.*—Federal regulations require that medicaid facilities must accept the rate established by the State as payment in full for medical supplies and services provided as part of routine care. Such services cannot be charged to a patient's personal funds.

At six facilities in three States, patients' funds were being charged for items which we believe should have been provided as part of routine care, including wheelchair rentals, restorative services, and routine medical supplies.

One facility in Missouri charged patients $60 a month for medical supplies and services whether or not they used this amount. All funds received by the patients up to $60 were used to pay this arbi-

trary charge. These funds included moneys that should have been applied to reduce the medicaid payment but were not.

Another facility in Missouri charged one patient $262 for the period January to July 1975 for medical supplies and services.

3. *Maintaining funds of deceased and transferred patients.*—Federal regulations are silent as to the disposition of the personal funds of transferred or deceased patients. Two of the five States visited had regulations concerning the disposition of deceased patients' personal funds. These regulations provide for funds of deceased patients to go to their estates, family, or the State. In California, one of the States with such regulations, one facility was maintaining funds of deceased patients. In addition, eight facilities in three other States without such regulations were also maintaining funds of deceased or transferred patients. At one facility, as of April 1975, the balance of deceased patient funds totaled $17,762, of which $11,013 had belonged to patients who had died before April 1, 1974. Officials at this facility told us these funds would eventually be transferred to the facility's operating account.

4. *Keeping interest earned on patient funds.*—As previously discussed, an SRS memorandum dated August 18, 1975, stated that interest earned on a patient's funds belongs to the patient.

Interest on Funds Kept by Facilities

At four facilities in three States we noted that interest earned on patient funds was being kept by the facilities. At one facility the interest earned amounted to $13,200 since 1969, and at another facility the interest earned from October 1968 through December 1974 amounted to $1,639.

In addition to the problems I have already discussed, we also found: 11 facilities in 5 States used patient funds to pay operating expenses, including one in California that had used patients' funds as collateral for a loan for operating purposes. Twenty facilities in five States had poor procedures for documenting transactions in patient fund accounts. A common weakness was not properly documenting with receipts how funds were spent by third parties such as relatives on a patient's behalf. Five facilities in two States allowed patients to accumulate personal funds above the State resources limit instead of applying the excess funds toward the patients' cost of care. Sixteen skilled nursing facilities in four States did not provide patients with at least a quarterly accounting of activity in their accounts as required by Federal regulations.

Following is an extreme example of how a specific proprietary facility in California improperly handled patient funds.

As of July 1, 1975, there were 91 patients in this facility, 77 of whom were covered by medicaid. The State last inspected this facility for participation in the medicaid program in March 1975. At that time, the inspection did not identify any deficiencies involving patient funds and the inspectors indicated that the facility was in compliance with patient fund requirements.

HEW regulations require nursing homes to include certain medical supplies in the medicaid per diem rate. Contrary to these re-

quirements this facility arbitrarily charged medicaid patients for such medical supplies as gauze dressing, catheters, and tubing.

This facility had a central supply unit provide medical supplies for patients. An individual schedule of use was prepared for each patient, except for medicaid patients, showing the supplies used by each. A single list was prepared for medicaid patients showing the total supplies used. There was no listing of individual medicaid patient usage.

The facility's bookkeeper stated medicaid patients were charged based on their ability to pay and not on their actual usage. She said this was done to reduce the facility's medical supply expenses.

This facility charged some patients $3 per month for maintaining their funds. The bookkeeper stated that the $3 service charge was assessed when (1) a patient receives a check which has to be split between his cost of care and his personal allowance, and (2) when a patient has "many withdrawals" from his trust account during the month. The bookkeeper further stated that there was no criteria for how many transactions constituted "many withdrawals."

We discussed this charge with the administrator. He stated that all patients should have been assessed this service charge to compensate for the amount of time the facility's accounting staff spent on patient funds. As previously discussed, an SRS memorandum, dated August 18, 1975, states that a facility may not charge a medicaid patient for managing his personal funds.

The California Administrative Code provides in general that money of deceased patients entrusted to a licensed facility should be turned over to the patients' estate or the county public administrator within 30 days of death. Seven deceased patient accounts we examined had balances that were not surrendered to the patient's estate. Balances in these seven accounts ranged from $12 to $1,041, with dates of death as early as January 1974. The facility used the funds in several of these accounts to offset bad debt losses. We found no evidence that these patients' next of kin or the public administrator were advised of the balance of the patients' funds in these accounts.

This facility also had incomplete documentation for patient funds spent by facility employees on behalf of the patient, commingled patient funds with the facility's operating funds in violation of the California Administrative Code, and also failed to provide patients with a quarterly accounting of transactions in violation of Federal regulations.

States' Monitoring Activities

The States' monitoring activities pertaining to patients' funds involve the annual inspections required for certification for participation in medicaid, usually by the department of health, and periodic audits of such facilities by various State auditing organizations.

Inspections: With regard to inspections, HEW regulations require each skilled nursing home and intermediate care facility certified for medicaid to be inspected at least annually by State inspectors to determine whether the facility is in compliance with Federal regulations.

State inspectors as part of the certification process for skilled nursing facilities are required to determine that (1) the facility has

written policies with regard to patients' rights, and (2) the staff of the facility is trained and involved in their implementation. These policies and related procedures include safeguards that protect the personal financial affairs of patients. For intermediate care facilities, State inspectors must assure themselves that there is a written account available to residents and their families maintained on a current basis for each resident with written receipts for all disbursements made to, or on behalf of, the residents.

Michigan did not include patient funds in its certification process until August 1975. In 21 of the 24 nursing homes and intermediate care facilities in the other 4 States we visited, State inspection reports showed that the facilities were in compliance with the standards for patient funds. In our review, we found that all 30 of the facilities did not comply with 1 or more HEW or State requirements.

Moreover, there is some question as to the ability of inspectors to determine whether a facility has properly implemented the policies and procedures for handling patient funds. For example, in Missouri the facility survey is performed by a two-person team consisting of a sanitary engineer and an institutional advisory nurse.

During the survey, the sanitary engineer is concerned with such areas as the physical conditions of the facility, fire safety, and sanitation.

On the other hand, the nurse is responsible for completing the parts of the survey form that involve patient funds and/or patient rights.

The supervisor of the State's bureau of institutional advisory nurses informed us that during a survey of a facility a nurse would visually check to see if ledger cards or something similar had been prepared for the patient.

The nurse also checks whether the facility has written procedures for the handling of patient funds. The supervisor further informed us she doubted any of her nurses performed any verification of the transactions shown on a patient's ledger card because her nurses did not know how to verify that written procedures for patient funds were being followed.

State Audits Underway

In three of the five States we visited, State audit agencies made or were making a number of audits of patient funds. In New York, which has approximately 540 facilities, the State audit agency had completed 25 audits and another 36 were in progress as of April 1975.

These audits were comprehensive audits of the facilities which included (1) the determination of eligibility for medicaid; (2) the propriety of billings submitted by the facility; and (3) the propriety of procedures used in the receipt, maintenance, and use of personal funds paid to medicaid recipients.

The final reports or report drafts included the following deficiencies:

Proper records of the receipts and disbursements of patients' personal funds were not maintained;

One nursing home had used about $7,000 of a total of $16,000 in patients' funds to meet operating expenses; and

One facility kept patients' funds in separate envelopes bearing the patient's name. This facility made bulk purchases of clothing for patients, then an employee collected the funds for payment for such purchases from all the envelopes without regard to who benefited from the purchases.

We visited two of these facilities in New York approximately 7 months after the reports were issued to the facility to determine whether corrective actions had taken place. In each of these two homes we found that no corrective actions had been taken.

As of May 30, 1975, the Florida Audit Agency had issued one report on patient funds. This report dated January 31, 1974, cited activities of three Dade County nursing homes and questioned the handling of about $75,588 in patient funds.

Activities questioned by the Florida Audit Agency included charging for: Wheelchairs and bedspreads, clothing which patients testified they did not receive, physical therapy, and recreational programs.

An additional 23 nursing home audits were in various stages of completion. However, in January 1975, all nursing home audits were suspended, and the audit effort was directed to other areas. These audits were resumed in October 1975.

Michigan made periodic audits of nursing homes. Audits of nursing homes in 1973 and 1974 disclosed 18 instances where nursing homes were commingling patients funds with operating funds. California and Missouri have not made audits of patients' funds maintained by skilled nursing homes and intermediate care facilities.

In summary, we believe that it is fair to conclude that HEW has issued very limited guidelines to the States regarding patient funds. Accordingly, HEW has relied on the States to specify and control the method to be used by nursing homes and intermediate care facilities to handle patient funds. Certain States have detailed regulations on handling patient funds while others have limited regulations or guidelines.

State Monitoring Efforts "Limited"

Monitoring efforts by the States have been limited in reviewing compliance by nursing homes and intermediate care facilities with patient funds requirements. Monitoring efforts by the States in connection with inspections for participation in medicaid have not been adequate to assure compliance with patient funds requirements by intermediate care and skilled nursing facilities.

Further, there appears to be a question as to whether the people making such inspections are adequately trained to deal with this issue.

States' audits disclosed deficiencies similar to the ones we identified, but it appears that such audits have had limited impact in correcting the problems.

Accordingly, there is a need for HEW to provide minimum standards to the States for controlling patient funds. Further, there is a need for expanded States' monitoring to assure that facilities comply with patient fund requirements.

This concludes our prepared statement. We would be pleased to answer any questions which you may have on this statement.

Senator Moss. Thank you, Mr. Ahart, for your statement.

What is HEW doing now? You indicated that HEW should provide minimum standards. Is it taking any action in this area?

Mr. AHART. The Social and Rehabilitation Service of HEW has prepared a draft instruction which it intends to send out to the States. It would emphasize the need to monitor this area, to issue guidelines on this area to the nursing homes, and to insure compliance.

Now that's in the draft stage at this time and I don't have word on just exactly when it will be issued, but it should help.

Senator Moss. Is there any potential requirement there as to who might audit this particular kind of practice? You indicated in some instances in which an inspection team is simply a sanitary engineer and a nurse supervisor, neither of whom would specialize in looking at the handling of funds. Is HEW directing anybody to do that?

Mr. AHART. Well, HEW will be directing them to monitor this area. I don't think it's specific as to whether it ought to be the inspection team, which of course would have to have the capability then to look at this particular area in nursing home operations, or whether it would be a State audit agency which would go in and look at the financial aspects of the nursing home operation including the nursing homes' administration and handling of patient funds.

Senator Moss. Now, you indicated your audits were performed in certain States. How were they selected? Had you received complaints from them?

Mr. AHART. No; we selected the States, Mr. Chairman, on the basis principally of getting some geographic dispersion and also to insure that the five States would be located in five different HEW regions so we could look at five regions as well as five States. But there were no particular complaints, to my knowledge.

Senator Moss. Did the auditing teams come from the Washington office or did they come from the GAO regional office?

Mr. AHART. All our auditing teams, Mr. Chairman?

Senator Moss. Yes.

Mr. AHART. These were drawn from our regional offices located generally in the same regional cities as the HEW regional offices.

Senator Moss. And then on the selection of the homes to be audited, was that a random selection or was that also structured in some way?

RANDOM SAMPLING ASSURES DIVERSITY

Mr. AHART. Well, its structure was not random; the sample was structured to make sure we had homes of different sizes, homes of different types in terms of proprietary profitmaking homes, nonprofit homes, and those that are publicly operated.

Senator Moss. The overall picture that I get from your report is that there hasn't been much attention paid to this matter. What is done with the patients' funds is sort of hit-and-miss, just depending on the home or the States. There is a general lack of supervision by most States, depending on the discretion of individual homes. Is that a rather fair statement?

Mr. AHART. Yes; at the present time it does depend on what initiative has been taken by the State. It's an area that has been largely ignored on the Federal level and one which, as I indicated, does need some concerted attention to safeguard the financial interest of the patients in the nursing homes.

Senator MOSS. Did you learn of any instances where the patient or the patient's family instituted any action or made demand on the funds that were not turned over to the patient?

Mr. AHART. I have no personal knowledge of that, Mr. Chairman. I would like to ask Mr. Pittsley if he became aware of any such situation?

Senator MOSS. Mr. Pittsley.

Mr. PITTSLEY. Mr. Chairman, we were asked to make a review of the funds in custody at the nursing homes. We did not go outside of the nursing homes.

Senator MOSS. I was wondering if, perhaps, in the area where the patient has died, at least you would expect the administrator or whoever the survivor was, to make some demands on these funds.

Mr. AHART. I would expect so, too, Mr. Chairman, in those cases where the survivors or the relatives were knowledgeable of the existence of the patients' fund account. But in many of these cases the patients under medicaid in nursing homes don't have that close a relationship with relatives, and the relatives may not know of the existence of the fund or the amount.

We did find cases such as indicated in California where there is a requirement under State licensure law of notification to the next-of-kin, but the notification was not given.

Senator MOSS. You indicated that the instructions from HEW were being drafted. Is there any deadline or do you know what time they intend to have all these instructions out to the States?

Mr. AHART. I don't believe I do. Let me ask Mr. Pittsley if he has any word on that.

No Deadline for Proposed Drafts

Mr. PITTSLEY. I don't believe HEW has any knowledge, Senator, of when these will be issued. These were just proposed drafts and have not gone through the complete system required to get these instructions out.

Senator MOSS. Your audit hasn't been put in final report form yet; is that what you told us?

Mr. AHART. It has not been put in final report form yet. We expect to issue a report to the subcommittee on the patient fund review about the end of the year.

Senator MOSS. By the end of the year. Will a copy of that go to HEW?

Mr. AHART. Yes.

Senator MOSS. Well, it would appear to me that this indicates what we suspected, that there has just been very lax supervision and something needs to be done.

As you know, I have introduced a bill, designated S. 1572, which seeks to amend the Social Security Act to afford greater protection

to patients' accounts. Are you familiar with that bill and if so, are you prepared to comment on it?

Mr. AHART. I'm not personally familiar with it, Mr. Chairman. Let me ask my colleagues if they have seen the bill and if they have any comments, they can make them.

Mr. PITTSLEY. No, sir.

Senator MOSS. I will have to circulate copies of the bill.

Mr. AHART. We will be happy to look at it.

Senator MOSS. Well, what I'm afraid of, and what I think maybe your audit shows is that because this seems like a small amount of money, this $25 a month you're talking about per patient, that nobody paid too much attention to it. We just sort of let it be handled hit-and-miss in various ways.

But if you will multiply that by the number of recipients that are entitled to it and in fact do draw the $25 a month, we are soon up into a large amount of money, and besides the principal on $25 ought to be just the same as it is on $2,500 or any other large amount.

It certainly should be accounted for; it should be used properly, and the taxpayers should be assured that what we have set aside by law goes to the benefit of that patient and it is expended for that purpose and no other.

My colleague, the ranking minority member of the subcommittee, the Senator from Illinois, has arrived, and I don't know if he has any comment at this point.

STATEMENT BY SENATOR CHARLES H. PERCY

Senator PERCY. Mr. Chairman, I would first like to say that it's with nostalgia that I'm back in this room. It's been 7 years since I sat at this table as a member of the Aeronautics and Space Committee. We appreciate your making available these facilities.

I don't think we should look at the use of these funds just in terms of the dollar value. I have mentioned before that I have observed that the older we all get, the more magnified small mishaps, events, or amounts of money become.

The feeling that someone is ripping you off, the fact that things are being mismanaged, these things cause aggravation. It's a small amount of money, but it becomes a very big thing sometimes to people. I think the administration of those funds is extraordinarily important to them, and beyond even the amount of money.

Mr. Ahart, you have suggested tougher Federal regulations and more stringent State controls. But you have said nothing about enacting legislation. What changes in law might be necessary to better protect the rights of patients in this area?

Mr. AHART. Certainly, I think this is an area in which there's an option to handle it administratively by HEW through regulations. I think they have the authority to do that.

It could also be handled by some specific requirement of legislation to require HEW to do that and to lay out some guidelines. We haven't yet considered a specific legislative amendment which would

be appropriate here. We would be happy to look at the chairman's bill and see if that would do the job.

We do intend to make recommendations to HEW as to what kinds of regulations and guidelines they should put out to govern the States' activities in this area.

Senator PERCY. It would be very helpful to us. I think we have an ultimate responsibility in that area and if there are suggestions you can make to us, we would appreciate it. Our staff has enjoyed working with your people on this.

HANDLING PATIENT ACCOUNTS

My only other question regards the differentiation that you might have seen between proprietary and nonprofit facilities. Your statement seems to imply that some facilities have very little difficulty in segregating accounts for patients from other accounts of the nursing home and managing these accounts quite accurately and quite ethically for the benefit of patients. Is it true that you did find some homes that handled them very well indeed?

Mr. AHART. We had some homes with only a few deficiencies, with very few deficiencies. We had others that had deficiencies in quite a number of areas.

I would have to ask Mr. Pittsley whether or not we tried to analyze these and categorize the number of deficiencies, proprietary versus the nonprofit versus the public. He may have information on this.

Senator PERCY. Mr. Pittsley, before you get to that, could you tell me if, generally speaking, you find homes no matter whether proprietary or otherwise, do handle the accounts with care, with accuracy, carefully segregating them to the full satisfaction of the patients themselves, or if the mismanagement of those particular funds is a universal problem?

Mr. PITTSLEY. Senator, although I have not made a real analysis of these, my feeling is that it matters not whether they are proprietary, nonprofit, or public, they are all mismanaging the funds.

Senator PERCY. They are all mismanaging the funds.

Mr. PITTSLEY. All three types.

Senator PERCY. Now, where you have found cases where they are handled well, where there is no cause for complaint, where there is accuracy and full satisfaction by the patient, what accounts for this? Is it better management or is there a question of integrity and honesty? Is it just a question of attention to detail? What is the formula for success, and how do we get all homes, proprietary and otherwise, to follow that pattern?

Mr. AHART. Let me respond to that, Senator. I think probably one of the key factors is the amount of interest and guidance given by the State to the nursing homes to tell them what is really expected of them.

I am just looking at the schedule here that I have. California had the most comprehensive regulations and the homes we looked at in California on the average had the least number of deficiencies.

I would expect that you can have substantial improvements if you really get the States, or require the States, to tell the nursing homes what is required in terms of taking care of patients' accounts, what's required in terms of accounting, what is required in terms of not commingling the funds with the operating funds and so forth.

And we only found three where there were actually shortages of patients' funds. But you did have commingling, temporary use of funds for operating purposes, use as collateral on loans, poor recordkeeping, charging for things they shouldn't have been charged for. Probably it just may well be a lack of guidance to them as to what is expected, what they can charge for and so on.

Senator PERCY. Now our chairman feels very strongly as I do that we can't go around auditing everything. But you picked five States and found this kind of abuse. There are still 45 that you haven't gone into.

Mr. AHART. That's correct.

GIVING HOMES "FAIR WARNING"

Senator PERCY. We ought to put everyone on notice right now that you could go in and that we might order you to go into any State and that they ought to clean this up. Certainly I hope the media that covers this field would say this is an area that is really disgraceful in the way it's being handled. The field is just inviting more regulation, more control, and then they will be coming down here screaming, "We can't run our places because we've got so much regulation and control."

There is every evidence that all they do by their sloppy management is invite that kind of control, and they are the ones who are guilty of the kind of controls that are going to have to be put in, if we have to do it.

You have covered five States. You did not go into Illinois, did you?

Mr. AHART. Illinois was not one of the States.

Senator PERCY. How did you select the five States?

Mr. AHART. The States were selected basically to get a geographic dispersion and also to make sure that each one of the States was located in a different HEW region, so we could look at what the HEW offices were doing in terms of guidance as well as what was happening at the State level.

Senator PERCY. Well, certainly, let everyone be on notice you're going to be asked to go into more States. I will certainly ask you do so. I think you have performed a fine service. Once again, we're very grateful to you.

Senator Moss. We would like to call Mr. John Goff and let him take his place while the Senator is getting ready.

Senator PERCY. I would like to say that I was just advised last evening by majority counsel of the nature of the testimony to be given now by John Goff. I have never met Mr. Goff. He worked for the government of the State of Illinois as section chief of special projects, Bureau of Quality Control of the Department of Public Aid.

The summary that I was given last night leads me to believe that this testimony could be exceedingly damaging. I would therefore ask the witness to be sworn. I would ask also that we reserve the right to recall the witness for cross-examination and also that we offer to the State of Illinois and to our Governor the opportunity to present testimony in answer to any of the charges that are made.

I want Mr. Goff to understand that I do so without impugning in any way my feeling of his integrity; that we are always grateful to a witness who has the courage to come forward and testify.

But we have to be extraordinarily careful without regard to personality, whenever a reputation can be damaged. Whenever injuries can be done, we want that witness to know he is giving sworn testimony, that he will be held accountable for what he says, that he will be held in contempt if the testimony is untruthful or misleading, intentionally so, and that the people whose characters are impugned will be given the opportunity to respond.

Is that fully understood? Mr. Chairman, is that in accord with your wishes and desires?

Senator Moss. Yes, that is in accord with the desires of the chairman and the committee, and we will hold a later hearing if there is a request from any who are involved in this matter to give testimony before the committee, and I appreciate your explaining to the witness the consequences for which we must make provision.

Would you stand, Mr. Goff, and be sworn, please? Raise your right hand.

[Whereupon, John Goff was sworn.]

Senator Moss. We welcome you before the committee, Mr. Goff. John Goff is the former section chief of the Quality Control Division of the Illinois Department of Public Aid in Springfield, Ill., and at our request, he has come here to testify before this subcommittee, and we are very glad to have you. We understand your testimony might be quite stirring and we do commend you for your courage and your willingness to come forth and testify as we try to get to the bottom of many things that seem to be amiss with the medicaid and medicare program.

With that, you may proceed, Mr. Goff.

STATEMENT OF JOHN GOFF, FORMER SECTION CHIEF, QUALITY CONTROL DIVISION, ILLINOIS DEPARTMENT OF PUBLIC AID, SPRINGFIELD, ILL.

Mr. Goff. My name is John Goff. I am a private consultant with government institutions in Illinois. I have been asked to testify before this committee because of the experiences I had in 1973 and 1974 when I was section chief of special projects, Bureau of Quality Control, Illinois Department of Public Aid. In that capacity I supervised over 200 staff including auditors, investigators, case reviewers, data analysts, computer specialists, and statisticians.

At any given point in time, the special projects section had 30 projects including massive computerized income verification sys-

tems, computerized employment crossmatch systems, case review and investigation projects, medical auditing and investigation projects, and caseload projection assignments, to name some of them. These projects saved the State $40 million in fiscal year 1974.

During the summer of 1974, I launched a series of investigations and audits of medicaid payments at the direction of Joel Edelman, who was then the director of the department. I will not speak of the types of fraud that we found being committed against State and Federal agencies since other witnesses are addressing themselves to those matters. Rather, I have been requested to inform this committee of probable reasons why Federal and State investigations of medicaid abuse in Illinois have, to date, yielded no significant results.

The Illinois Department of Public Aid has been under criticism for over 2 years from citizen groups, medical groups, the news media, and various State offices and Federal agencies to clean up its program waste. And rightfully so.

In fiscal year 1975 alone, the department wasted over one-quarter of a billion dollars on grant and medical payments to ineligible and overpaid cases. Separate from this is the waste caused by outright medical fraud on the part of medical vendors.

The Illinois Legislative Advisory Committee on Public Aid has estimated the vendor fraud at $100 million a year. That is a conservative figure and does not include overutilization or unintentional errors, only fraud. The major reason why this waste has continued in Illinois is the direct interjection of politics into the management and administrative processes of the welfare department.

Over 3,000 Ineligibles Detected

I first became aware of the direct nature of the political interference in early 1974 when my section was pursuing the cancellation of over 3,000 ineligible welfare cases detected by one of our special projects, the income verification program.

The director at that time, Joel Edelman, called me from Washington, where he was on a trip, and informed me that he had just spoken to the Governor, and the Governor ordered him not to cancel those cases, most of which were on Chicago's South Side, until after the primary election being held the next week.

I informed the director that $100,000 would be paid to ineligible cases if I followed the Governor's order and thus I felt obligated to cancel the cases. The director informed me that I had done an outstanding job, but despite that, if I canceled the cases, he would have to fire me.

I stayed up that entire night trying to decide what to do. The next morning I began canceling the cases. The director, upon his return from Washington, apologized to me and stated that this was typical of the political pressure he has been receiving from the Governor's office, and that he was sick and tired of it. He resigned several weeks later after 60 patronage staff were placed on the department payroll by the Governor's office.

Attempts have been made to recruit civil service personnel working on federally funded programs to work in political campaigns supported by the Governor. This is a clear violation of the Hatch Act.

A political arm of the Governor, the Illinois Democratic Fund, attempted to recruit staff in my management analysis section to work in the primary campaign earlier this year in Chicago. The candidate they wanted staff to work for was a Mr. Schamberg, the brother-in-law of a high-salaried patronage worker on the welfare director's staff. This attempt was stopped after I confronted the individuals involved.

The director, James L. Trainor, was informed about this, but to the best of my knowledge, has not raised the question of the propriety or legality of this type of recruitment by the Governor's workers with the Governor.

The Federal quality control sample for January through June 1975, period was altered, or as regional HEW staff have phrased it "* * * was deliberately misunderstood" by State welfare officials on orders from the director, James L. Trainor.

This sample is quite important since it forms the basis for the Federal Government's withholding of millions of dollars from the State for its high rate of ineligibility. Any tampering with this sample can cause it to be totally invalid and yet the welfare department, on orders from its director, attempted to withhold information on 74 cases from the Federal Government. State and Federal quality control staff have assured me they will testify to this, if so requested.

Task Force Formed

Illinois' answer to the charges of abuse and corruption in the medicaid program was the formulation of the Governor's medical payments task force. This group was formed in the fall of 1974 under the direction of Donald Page Moore, the head of the Governor's Office of Special Investigations and under the management of John Simon, a private attorney. I was a member of that task force.

During my assignment to the task force, I was specifically instructed by the welfare director, in front of a witness, not to share any specific or technical information with the U.S. Department of Agriculture auditors that were attempting to audit Illinois' food stamp program. It was hoped that by obstructing their progress, they would grow discouraged and simply go away. The auditors didn't do that. After a year's delay we now know that the administration of the Illinois food stamp program is the worst in the Nation with 51 percent of its cases being ineligible.

It was also during this period that Senator Percy, I believe, requested the General Accounting Office to audit and inspect the Illinois medicaid system. The same approach was tried on the Generel Accounting Office teams.

On the director's orders, no specific or technical knowledge was to be given to GAO. The auditors commented to me privately that there was obviously something going on but because of the complexity and the politics they "couldn't get a handle on it." Thus,

their report reflects what they were allowed to see—not what was there.

The regional audit staff from HEW were also attempting to look into vendor fraud during this period. When they asked me what vendors they should audit, I told them specifically that I was under orders from the director not to divulge any specific information to any Federal audit group. I hoped this blunt statement would tell them what was going on. Apparently it didn't, because they went away and never requested any more information. To the best of my knowledge HEW never completed any vendor audits in Illinois that were even close to the hundreds of fraud cases in existence. Apparently the HEW regional office didn't believe the allegations of widespread fraud or they aren't very persistent people.

John Simon was paid over $100,000 for his work on the task force. Simon reported that he found only six vendors and only $300,000 that were questionable. To this date, all of that amount has not been recovered by the department and none—absolutely none—of the vendors have been prosecuted.

Senator PERCY. What is John Simon's political affiliation?

Mr. GOFF. He has no particular political affiliation directly that I know of. I believe his father is a judge in the Chicago area.

Simon's assistant on the task force, Laura Staples, was a member of the Governor's office of special investigation. Immediately prior to her work on the task force, she was separated from the Better Government Association for what was described to me as "political espionage." She had apparently been releasing highly confidential information to the Governor's office for political purposes while she was a member of the BGA.

ALLEGED CONTRIBUTIONS UNDER INVESTIGATION

Donald Page Moore, head of the Governor's office of special investigation, and appointed by the Governor to head the task force, admitted to me, after I confronted him, that certain individuals under investigation by my staff had made significant contributions to his political campaign for State's attorney in Chicago.

I told him I intended to pursue the matter and that was the last time I talked to him, despite the fact that we had been talking every other day for several months.

Shortly thereafter when I attempted to pursue the investigation of these persons, a member of the Office of Special Investigations threatened my staff by stating that anyone continuing to investigate these people would go down with the ship.

I continued the investigation and shortly thereafter was removed from the task force by the welfare director, James L. Trainor. I was given no explanation other than the agency was reorganizing.

The welfare agencies public information officer, who was assisting the quality control staff in the medical investigation, was also threatened by a member of the Governor's Office of Special Investigations, Richard Dunn. The public information officer was told to "think of her family and career" and "to leave this medical business

alone." The threat was effective since she resigned shortly afterward and left the State. The public information officer who replaced her also resigned after a brief stay.

The task force's final report in the spring of 1975 is inaccurate, biased, and purposely erroneous. The authors of that report knew that data developed by my quality control staff on assignment to the task force showed that special treatment was received by factor and billing companies under investigation, yet they choose to deliberately obscure this.

While the welfare agency dismissed two employees for accepting gifts for favors done to these factor companies, no charges were brought against the individuals by Trainor, Simon, or Moore, and the report denies any collusion or impropriety on the welfare agencies part.

Fraud May Be Increasing

Tens of millions of dollars as opposed to the $300,000 the report identifies are actually recoverable from medical vendors. Dozens of vendors, as opposed to the six the task force report identifies, are actually involved in wholesale fraud. The fraud is still continuing, and I believe has actually increased.

In conclusion, it should be noted that money has been diverted away from the purposes for which it was appropriated by Congress. Middlemen are taking dollars that were earmarked for direct medical care to the aged and poor. The State of Illinois has compounded the problem by trying to sweep it under the rug. Vendors are so comfortable in the security that the Illinois Welfare Department will not prosecute them.

Solutions are not easy, but neither are they new. If government and the medical profession were to apply themselves to the problems; if they were to enforce current laws and regulations by utilizing existing sophisticated techniques; and if sufficient staff were made available for investigations and prosecution, I believe the problem could be minimized in a very short span of time.

The greatest danger I see is the growing sentiment to move to a totally new national health care plan without identifying and eliminating those individuals from the new plan that were committing fraud under our current medicaid programs. We would simply compound the problem and place the integrity of the new program in serious jeopardy.

I thank you for the opportunity to testify before this subcommittee.

[The following material was part of Mr. Goff's prepared statement, but was not read into the record.]

Problems

Total lack of Federal-State cooperation in investigation.

Lack of sophisticated audit techniques/and further an almost total lack of audits by HEW in medical vendor area.

Mixing social workers and investigators in the State agency doesn't work; the head of the agency must be schizophrenic.

Lack of manpower in State to perform sufficient audit and investigator capacity.

General lack of technical staff in the medical fraud investigation area.
Exclusion of medical groups from the audit/investigation process.
"White collar crime is OK" approach must be overcome.

SOLUTIONS

Creation of an independent Federal investigatory group in medical fraud.
Application of sophisticated techniques using the computer to isolate and identify medical fraud.
Inclusion of medical societies in audits to allow them to "police up" their own profession as they have requested.
Discouraging political interference in bureaucratic processes through indictment and prosecution if necessary.
Demanding a much more informed and stronger approach by HEW regions to insure proper spending of Federal tax dollars.
Training Federal auditors and investigators in medical fraud techniques.

Senator PERCY. Mr. Goff, we thank you. First, would you indicate who instructed you not to share information with the GAO auditors?

Mr. GOFF. I had several conversations, during the stay of GAO in Illinois, with the director, James L. Trainor, upon which occasions he told me directly not to share specific technical information concerning who we were auditing or investigating with the General Accounting Office staff.

This was also related to me by the senior assistant deputy director, Robert Wessel, on at least one occasion.

Senator PERCY. In other words, James Trainor, who is presently head of the Illinois Department of Public Aid, instructed you not to share information with the Federal GAO auditors and this is the same person that also told you not to share information with USDA and with the HEW auditors?

Mr. GOFF. Yes, it's James Trainor.

COVERUP SUSPECTED

Senator PERCY. Did you consider this an obstruction of justice and a coverup?

Mr. GOFF. I would not feel qualified to draw that conclusion.

Senator PERCY. Knowing what you know now, when there's an audit being made of Federal funds by Federal auditors, and you're instructed not to give them information they need to determine what happened to those funds, would you consider that a coverup?

Mr. GOFF. Yes, I would consider it a coverup. I'm not sure I'm technically qualified to state whether it's an obstruction of justice or not, Senator.

Senator PERCY. What information were you asked not to share with GAO?

Mr. GOFF. The specific quote was "technical and specific information." The director elaborated on it by saying he wanted no names of particular vendors under investigation or under audit to go to any Federal audit group.

Senator PERCY. If you had furnished this information to GAO, what effect do you suppose it would have had on the GAO report made last April?

Mr. GOFF. I believe they would have found widespread vendor fraud and the possibility of collusion in Illinois.

Senator PERCY. And it would have led them to carry their investigation farther than they did?

Mr. GOFF. That's my belief, Senator.

Senator PERCY. It would have been a material piece of evidence that the auditors should have had?

Mr. GOFF. That is my belief, Senator.

Senator PERCY. And do you believe that public officials, regardless of whether they are Federal or State, should make auditors aware of and should be diligent in pursuing fraud of that kind?

Mr. GOFF. Very definitely, Senator.

Senator PERCY. Why were you ordered to withhold information? Was any reason given to you?

Mr. GOFF. None. No, Senator, no reason.

Senator PERCY. Did you at a later time supply this information to other officials or agencies?

Mr. GOFF. Yes.

Senator PERCY. To whom?

Mr. GOFF. The information is currently with the attorney general's office in the State of Illinois.

Senator PERCY. Was it provided to any other individual?

Mr. GOFF. The Office of the State Comptroller has part of the information.

Senator PERCY. Was it provided to any individual connected with the public assistance programs? Did you, for instance, provide that information to John Simon?

Mr. GOFF. Oh, yes, Simon had all of this information because I reported directly to John Simon on the task force.

Senator PERCY. When that information was provided to John Simon and to the task force, what action did they take?

Mr. GOFF. The action that I'm aware of is the formulation of the report to the Legislative Advisory Committee.

ORDERED NOT TO CANCEL PAYMENTS

Senator PERCY. I'd like to go back also just to identify every individual by name because sometimes you have used titles. You did indicate that Joel Edelman, who was former IDPA director, ordered you not to cancel payment for 3,000 recipients who were fraudulently receiving aid in Chicago. Who did that individual report to, Joel Edelman?

Mr. GOFF. Who did Joel Edelman report to?

Senator PERCY. Yes.

Mr. GOFF. He reports to the Governor, I believe, Senator.

Senator PERCY. And the Governor at that time was who?

Mr. GOFF. Daniel Walker.

Senator PERCY. Again, was there any reason given as to why you were given such an order?

Mr. GOFF. The statement was that the cancellations were to be withheld until after the primary election which I believe was about 1 week away.

Senator PERCY. Could you identify who was running in that primary election and who was affected by that primary election and its outcome?

Mr. GOFF. No, I couldn't.

Senator PERCY. Who threatened to fire you?

Mr. GOFF. During this period?

Senator PERCY. Yes. If you canceled these payments.

Mr. GOFF. Joel Edelman did——

Senator PERCY. And again on whose orders then and what authority stood behind this order to fire you?

Mr. GOFF. He told me directly that he was acting specifically on the orders of the Governor not to cancel the 3,000 cases—the order to fire me would have been Edelman's.

Senator PERCY. And there was no equivocation about it?

Mr. GOFF. No, it was absolutely——

Senator PERCY. Categorically, it was specifically on the order of the Governor?

Mr. GOFF. Specific.

Senator PERCY. What officials from Governor Walker's staff attempted to recruit IDPA personnel to work in the Chicago political campaign?

Mr. GOFF. There were two that I was aware of. They are members of the Illinois Democratic Fund, I believe. I am sure one of them is; I'm not quite sure about the affiliation——

Senator PERCY. From your own knowledge, can you give us any more information about the Democratic Fund?

Mr. GOFF. In what way, Senator?

ALLEGED HATCH ACT VIOLATIONS

Senator PERCY. Well, specifically, could you elaborate on what you mean by recruiting IDPA personnel to work in the Chicago political campaign? In other words, these individuals would stay on the Illinois Department of Public Aid payroll but would be workers who would then be asked to or requested to work on behalf of a political campaign; is that right?

Mr. GOFF. Yes.

Senator PERCY. And work in what way, during office hours or in a volunteer effort?

Mr. GOFF. I believe they were asked to work a weekend and take a Monday and a Friday off to distribute campaign literature in Chicago. I didn't go into it much——

Senator Percy. Work on a Saturday and a Sunday and then also on a Monday and Friday; that's a pretty good weekend, isn't it?

Mr. GOFF. Yes.

Senator PERCY. So that would be Monday and Friday they would be working in political activity, while at the same time, was it your implication that they were to take a leave of absence on Monday and Friday?

Mr. GOFF. The information I received was that they were going to attempt to take a sick day both those days.

Senator PERCY. They would draw sick pay on those days?

Mr. GOFF. Yes.

Senator PERCY. But they would be paid then out of these funds?

Mr. GOFF. Yes.

Senator PERCY. Is that contrary to any law that you're aware of?

Mr. GOFF. I believe it's a violation of both State and Federal law; I believe it's a violation of the Hatch Act, specifically.

Senator PERCY. Did you report this situation to the proper authorities in Illinois at the time?

Mr. GOFF. Yes, I did, Senator.

Senator PERCY. To whom did you report this situation?

Mr. GOFF. I reported it to my immediate supervisor, at the time, Mr. Gerald Slavens, in full detail.

Senator PERCY. Do you know what they did with it?

Mr. GOFF. I requested that Mr. Slavens read the Hatch Act to the public aid employee, which he did.

Senator PERCY. Mr. Chairman—our chairman has returned—and I will be very happy to yield to him for questioning.

I would like to mention a few items for the benefit of the Chair and Senator Brock, for their own background. The chairman has had a good deal of background with me in Illinois. We've appeared many times in the State on many different kinds of problems.

HISTORY OF INVESTIGATIONS

This particular inquiry originated on July 30, 1974, when I wrote to the Senate Finance Committee asking them to investigate Chicago media reports about medicaid fraud.

I think, Mr. Chairman, you are familiar with my home involvement with the Better Government Association. In the 1960's I told the Better Government Association that because we really had one-party government—there was not a single county official of the minority party. There was no watchdog. It was really a minority in Cook County in the 1960's and so I asked the Better Government Association, which was an association essentially reviewing candidates and endorsing them for public office, whether or not they couldn't perform a more useful function and become the watchdog as a substitute for an impotent Republican Party.

There was no check and balance in Cook County whatsoever. The last remaining officeholder that we had as State's attorney was defeated, a former Democrat, Ben Adamowski. And the Better Government Association did as I suggested and I agreed to serve as chairman of the Operation Watchdog section of Better Government Association together with Roy Ingersoll, I believe, who was then head of Borg-Warner. And we had a bipartisan group working on it, Democrats and Republicans.

The BGA became a very professional group. We hired an FBI agent to come in and be the chief investigator. Investigative work rapidly grew to be 90 to 95 percent of the activity of BGA and one of the outstanding chief investigators is now a consultant to our committee.

We linked up with Chicago news media in a way which is now being duplicated across the country. Whenever the news media would get a lead on something we'd throw investigators on it and work closely with them. The cooperation has been great indeed.

In this case, the Chicago Tribune took a lead. Other times, the Sun Times has taken the lead or the Daily News or WBBM–CBS, but what they do is put the spotlight of public attention on activities of this kind and try to eradicate them through sunshine, in a sense.

Now, on July 30, I asked the Senate Finance Committee to investigate these reports that the news media had been making about widespread fraud and abuse in the Illinois medicaid program.

As a result of this request, Senator Talmadge commissioned the GAO report made public on April 21, 1975. This report confirmed that improvements were needed in the management of the medicaid program, particularly in the investigation of suspected fraud and abuse in the medicaid program in Illinois.

But they were not able to confirm the existence of fraud and the question is: Did they push hard enough to verify specific reports of fraud or identify the particular kinds of fraud to which the Illinois system was most prone.

And here we have direct sworn testimony that there were orders to mislead and not provide the kind of leads the GAO auditors absolutely needed to fully investigate this program. Instead, the GAO report stated that IDPA reported that it had responded to the charges by initiating corrective action in every instance.

Action Reported To Be Underway

Moreover, the IDPA director, Mr. Trainor, told GAO that he had started action to deal with GAO's findings of lack of accountability of claims, unnecessary manual processing, ineffective use of computers, inaccurate files of those eligible to receive medicaid, and inefficient provider and employee training which delayed payment to providers and resulted in a turn to factoring companies. And finally the GAO report noted that Governor Walker established a medicaid task force to investigate the media charges and that the IDPA director established a unit which would produce computer programs and procedures developed by IDPA's special counsel to identify suspected cases of fraud and abuse.

Now, the testimony we are having this morning indicates what really went on and it is valuable testimony. I'm very happy to yield to the Chair and to Senator Brock for questioning and then I'll come back if any one of the questions I have prepared have not been answered.

Senator Moss. Thank you very much. I regret that I had to step out for some urgent telephone calls.

I do commend Mr. Goff for his candor and coming forward with this information. I have just a few questions. I confirm the fact that Senator Percy and I have been involved in a number of hearings in Illinois and we have run into some of the things about which he's been telling us.

In your statement, Mr. Goff, you said that the Illinois Department of Public Aid wasted one-quarter of a billion dollars in 1975. Where do you get that figure?

Mr. Goff. That figure was determined by the Quality Control Bureau, based on the rates of ineligibility in overpayments in the

AFDC program, the general assistance program, and the medical assistance no-grant program.

Senator Moss. Well, is the Quality Control Bureau then dealing with the failure to give the services as well as what the quality of services are?

Mr. Goff. In 1974, it was, Mr. Chairman. It is not currently doing so. I believe it is simply performing audits.

Senator Moss. You also stated that a small number of medical vendors in factoring companies are breaking the back of the Illinois welfare budget. Do you know the dollar amount that goes through factors in Illinois?

Mr. Goff. I have seen that. I can't recall that amount off the top of my head, Mr. Chairman. It's a substantial sum of money, in the millions of dollars.

Senator Moss. Do you know what amount of discount or interest rate the factors charge when they pick up these accounts?

Mr. Goff. That varies from factor to factor. To the best of my knowledge, it's a 15- to 40-percent discount.

Senator Moss. Fifteen to twenty percent?

Mr. Goff. Fifteen to forty percent. Depending on whether it's the doctors.

Senator Moss. Have you been able to determine whether the factor has any way of collecting his money more readily from the State than does a doctor or whoever turns over the account?

Gratuities Received for Expediting Handling

Mr. Goff. I would rather answer that question more fully at a later time due to certain matters that are under investigation. I can speak to one specific instance, however. Two employees were identified by my section and subsequently dismissed from the department for expediting the handling of a certain factoring company's bills. They received gifts and cash for that service.

Senator Moss. So you are aware of some cases of payoff to personnel on the inside to speed the payment along; is that right?

Mr. Goff. Yes.

Senator Moss. Can you expand on what the quality control sample is and what it means and why it would be advantageous to fool around with it, as you say?

Mr. Goff. Yes. I'll try. It's a fairly technical area. There are currently, I believe, about 225,000 AFDC cases in the State of Illinois. A random sample as drawn from that caseload, the random sample is approximately 1,320 to 1,330 cases.

Those cases are audited by the State quality control bureau who report their audits to the regional HEW Quality Control Bureau. Depending on the number of ineligible and overpayments they find, certain sanctions are placed against the State, monetary sanctions by HEW.

Senator Moss. Therefore, if you fool around with a sample, the State might relieve itself of some penalties; is that what you're saying?

Mr. Goff. Oh, most certainly. That's a very small sample and even in a small number of cases that are altered it has very significant dollar terms.

Senator Moss. You state that you and your staff were threatened with "going down with the ship." Who made the statement and what were the circumstances when it was said?

Mr. Goff. Laura Staples, who was a member of the task force and also a member of OSI made that to one of my staff in the Chicago office after she learned that we were continuing to investigate certain individuals, or at least became aware of the fact that we were investigating certain individuals. That statement is signed, dated, and witnessed by two other parties.

Senator Moss. Is OSI now—was that a State agency or a Federal agency?

Mr. Goff. I'm not sure if it was ever a State agency because the legislature refused to fund the agency. It was continued in existence, I believe, by placing the employees on other departments' payrolls, although I'm not sure about that point. They may have had some funds initially.

Senator Moss. In your statement you say that not one case of vendor fraud was referred to the attorney general for prosecution. Can you tell us how many investigators were assigned to the task force? What was it that they did during the 6-month period?

Investigations Not Thorough

Mr. Goff. I believe at any one time there were over 30 Illinois Bureau of Investigation inspectors, State police detectives, and OSI agents. During the time that I witnessed them, they wrote reports and occasionally went out and found out for us where doctors were actually located. I believe the majority of their time was not spent for any particular purpose.

Senator Moss. But you're not aware that a case was ever referred for prosecution to the attorney general?

Mr. Goff. No, there was none.

Senator Moss. What specific information was not given to the GAO or the HEW or the Department of Agriculture auditors that would have helped?

Mr. Goff. We developed during that period a wide variety of technical and sophisticated computer techniques to isolate vendor fraud. I believe there are 10 to 13 data processing runs that are quite helpful to auditors and investigators in isolating those individuals that they should check or investigate.

Senator Moss. But can you select which of that information was not turned over and how it would have been helpful had it been turned over?

Mr. Goff. Yes, I can. I can give you some specific examples. The single most easiest report to understand is called the duplicates list. It's simply a listing of duplicate medical payments to a particular case.

In many instances the same vendor was paid several times for the same service and that information was not made available to

GAO. It appears to me that that would be quite helpful to an auditor.

Senator Moss. Were the factors involved in any of this duplication of payments, claiming of duplicative payments?

Mr. Goff. I would prefer not to answer that until the investigation is completed.

Senator Moss. That is under investigation now; is that what you're telling us?

Mr. Goff. Yes.

Senator Moss. But you are aware that there were duplicate payments made whether the factors were involved or not?

Mr. Goff. Yes.

Senator Moss. And many? Is that what adds up to this quarter of a billion dollars that you gave as an earlier figure?

Mr. Goff. No, that's a separate figure. The quarter of a billion dollars is the welfare grant payments, including some medical payments to welfare cases. The vendor fraud is the $100 million figure that the legislative advisory committee has established.

Senator Moss. Now, very likely it will be charged that your testimony was politically motivated. What would be your reply to a charge of that sort?

No Political Motivation

Mr. Goff. I have lived in Illinois 29 years and I think anyone who has known me or worked with me knows that I'm not politically motivated. I have a masters degree in political science. Other than that, I'm not particularly interested in politics. I'm a civil servant and a government manager.

Senator Moss. Do you maintain that you don't care which political party is involved, if you see wrongdoing, you will point it out, are you telling us that?

Mr. Goff. Yes, I am.

Senator Moss. So you deny that your motivation is directed against a given political party?

Mr. Goff. A statement like that would be ridiculous.

Senator Moss. Now, you're working at the present time as a consultant. What specifically is the work you're doing now?

Mr. Goff. I am working as a consultant of the attorney general, reviewing medical vendor fraud, and also I'm a consultant with the office of the State comptroller and I'm reviewing the possibilities of preaudit systems that we may have potentially in Illinois.

Senator Moss. I see; what you have been telling us about came from your previous employment when you worked for the department in Illinois; is that correct?

Mr. Goff. Yes, exclusively.

Senator Moss. Well, again, I want to say that I appreciate your coming forward to tell us these things. We could of course examine it at considerable length. Is it often that it's estimated that $1 out of every $10 in medicare and medicaid is fraudulent or questionable payments?

Mr. Goff. I've heard that figure quoted several times; I've heard other figures too but it is a figure——

Senator Moss. Would this seem to be overestimated or underestimated from your general observation?

Mr. Goff. That would be very close.

Senator Moss. You think that would be a fairly accurate estimate; is that right?

Mr. Goff. It would be fairly close, yes.

Senator Moss. That would be 10 percent, then, of all funds?

Mr. Goff. Yes.

Senator Moss. So if medicare and medicaid expends $30 billion in a year, that might be $3 billion that might be fraudulently or inadvertently paid?

Mr. Goff. Yes, I have heard those figures too and I don't disagree with them.

Senator Moss. The Senator from Tennessee, do you have any questions you'd like to ask?

Senator Brock. What are we talking about in terms of your total expenditures in Illinois? On this quote of $1 billion on grants and medical payments, what would that be a part of? What would be the overall figure?

Estimated $1.8 Billion Departmental Budget

Mr. Goff. I believe the budget of that department is—this is off the top of my head—about $1.8 billion a year and about half of that figure is medical payment cost.

Senator Brock. So it's $900 million in medical payments and $250 million in welfare grant payments?

Mr. Goff. No; the $100 million is medical.

Senator Brock. But your gross error is a minimum, as you've stated, of $250 million plus $100 million?

Mr. Goff. Yes.

Senator Brock. They are separate and you would add them?

Mr. Goff. Yes.

Senator Brock. The $100 million wouldn't be part of the $350 million?

Mr. Goff. Yes, it is.

Senator Brock. $350 million lost out of $1.8 or $0.9 billion?

Mr. Goff. Out of the $1.8 billion.

Senator Brock. Considerably more than 10 percent?

Senator Moss. In that particular instance. I was talking about the $30 billion total that we spent.

Senator Brock. But that amount apparently is not the issue here.

Senator Moss. It didn't stop at 10 percent.

Senator Percy. The shoebox just began in Illinois. [Laughter.]

Senator Brock. On this matter of vendors, on page 6 of your statement, you said, in response to one of the questions from Senator Moss, that there are certain matters that you couldn't comment on. And I don't know if I'm going to make you respond the same way. But you state—

The authors of that report knew that data developed by my quality control staff on assignment to the task force showed that special treatment was received by factor and billing companies under investigation, yet they choose to deliberately obscure this.

This is the 1975 final task force report.

Now, can you describe for me, if it is not something subject to current investigation, the type of special treatment that the factors and billing companies received?

Mr. Goff. I can describe it in general terms, Senator, in relationship to the two employees that were dismissed from the department for special handling of factors' bills. They were expediting the shipment, handling and payment of those bills so that they were paid more quickly.

Senator Brock. But at this time you could not comment or would not be able to comment on the payment problems?

Mr. Goff. Yes, I could.

Senator Brock. Would you?

Mr. Goff. What—is there a specific question?

Senator Brock. Well, I'm wondering, have you not lumped factors and billing companies together in the same category?

Mr. Goff. Yes.

Senator Brock. And they're both discount——

Mr. Goff. Yes, that's correct.

Duplicate Billing Under Investigation

Senator Brock. What I'm reaching for is: Do you have evidence that the billing companies did duplicate bills with the tacit approval of the audit section so that they were assured of no investigation?

Mr. Goff. With the Chairman's permission, I'd have to avoid answering that question if I may at this time. That matter is under investigation; it's a very specific one.

Senator Brock. Then I guess that would conclude my specific questions on that and I'll yield to Senator Percy who has a great deal more knowledge on this subject. I would like to say, Mr. Goff, that for myself, at least, I compliment you on your testimony and courage in presenting it. This is not a small business; this is a very large business and I assume you've seen the particular hazards involved in your being honest and forthright. I appreciate your coming to testify.

Senator Moss. The Senator from Illinois has a couple of questions.

Senator Percy. Mr. Chairman and Senator Brock, 5 or 10 minutes ago I was handed a note indicating that Governor Walker had called and specifically asked for a delay in Mr. Goff's testimony. Obviously, it's not possible to accede to that request. It appears that the State would like to present counterevidence and so, therefore, I would request that at the convenience of the committee, at the earliest convenience of the committee, and whenever the Governor's office is prepared to offer testimony, that they be called for another hearing for that purpose. It's regrettable that it is not possible to have that testimony immediately, because I would really like to have it right along with the testimony given by Mr. Goff.

I did, however, advise the Governor's office of the testimony to be given this morning. They do have a representative here who has been here from the outset of this testimony, so the Governor will be fully apprised of the nature of the testimony. I just felt that it was potentially damaging enough that we wanted to put them immediately on notice so that they would have the opportunity to hear the testimony just as we on the committee have had an opportunity to hear it.

I'd like to ask about the waste of a quarter of a billion dollars. In our State, like in many others, we're having problems meeting payments because of the budget crunch. It is a major problem to balance our budget, to balance our expenses with our income.

You've testified that in fiscal year 1975 alone, the department wasted over a quarter of a billion dollars on grant medical payments to ineligible and overpaid cases. Then you say separate from this is the waste caused by outright medical fraud on the part of medical vendors. The Illinois Legislative Advisory Committee on Public Aid has estimated the vendor fraud at $100 million a year. That is a conservative figure which does not include overutilization or unintentional errors—only fraud.

Fraud on National Scale Could Be Staggering

So what we're talking about is an immense amount of money. I think quite rightfully you have said at the end of your testimony that we should not think of going into a national health insurance program until we know how to handle lesser programs involving smaller amounts of money. In national health insurance, you're talking about tens of billions of dollars and the chances for fraud would be absolutely unbelievable. Just to be clear whose money we're talking about, let's just take the quarter billion. Is half of this State tax money and half Federal tax money?

Mr. Goff. It would be somewhat less than half that amount because overpaid and ineligible general assistance cases are included in that, slightly less than half the amount is Federal dollars, slightly more than half that amount is State dollars. That's because the general assistance program is a totally State-funded program.

Senator Percy. But it's a very large amount of money.

Mr. Goff. Staggering.

Senator Percy. Who ordered the quality control samples submitted to HEW for January to June 1975 to be altered and in what ways was it altered?

Mr. Goff. The information I received was that the 1974 cases, including some ineligible cases which would affect the sample drastically, were withheld from any Federal regional office of the HEW office.

Senator Percy. Who was it that ordered this alteration?

Mr. Goff. The staff in that bureau have told me that it was James L. Trainor, the director of the department.

Senator Percy. Does HEW know about this alteration?

Mr. Goff. Yes.

Senator Brock. What size samples are we talking about? Seventy-four based on what size?

Mr. Goff. It would be 74 cases out of a total sample of 1,300 that represent a universe of around 245,000.

Senator Brock. But the 1,300 is your base sample?

Mr. Goff. Yes.

Senator Brock. Out of that, 74 cases could be 5 or 6 percent of the total sample, but of the overpayments it would probably be around 30 to 40 percent, wouldn't it? What I'm trying to pin down is the quantification of the statistical basis. If 20 percent of the 1,300 were found to be ineligible, that would be 260 people, out of these you withdraw 74. Now you're talking about something between 25 and 30 percent of the errors which you are writing out of existence in order to document your claim for funds from HEW. Now, is that a fair statement to make?

Mr. Goff. I believe it's fair to say that it's a very substantial number of cases and that 74 cases would totally invalidate the sample.

Senator Brock. It would reduce the error range from, say, 20 percent to 15 percent, in other words, a quarter or more?

Mr. Goff. Depending on the number of ineligible and overpaid cases involved, it could be much more than that.

Possible 30-Percent Reduction

Senator Brock. But if we're talking about a real significant reduction in the reported ineligible cases, we're talking as much as 30 percent reduction in the reported amount.

Mr. Goff. That's the potential. Whether that actually occurred——the reduction occurred—I don't know. All I know is those figures were not given to the HEW office.

Senator Percy. Your point, I think, is well taken, Senator Brock. If you tamper with a Gallup or Harris poll which involves 1,600 people, if you tamper with only a few of those, it magnifies the error at the other end of the line.

Senator Brock. You have to multiply by about 20, so you're really talking about 20 times 74 for 1,400 on the overall population basis. That's the same, 4 or 5 percent of that.

Mr. Goff. I believe the sample is less than 1 percent if you're talking about a few hundred or 25,000 cases, a sample of 1,300.

Senator Percy. Mr. Goff, I'd like to ask you a little more about the task force—the Governor's medical payments task force—which, to those of us who wanted to see a close followup on this; represented a reassuring delegation of responsibility. You indicate John Simon was the head of that task force and he was paid $110,000. For what period of time did he receive that payment? Did he receive that as an individual or did he receive that because he had paid salaries to other people under him? What was he paid for and why was he paid that amount and who paid it to him?

Mr. Goff. He received that amount of money solely as an individual.

Senator Percy. Solely as an individual?

Mr. GOFF. As an individual, yes.

Senator PERCY. For what period of time? How many years did it cover?

Mr. GOFF. I believe that was spread over 11 or 12 months.

$110,00 FOR YEAR'S WORK

Senator PERCY. Eleven or 12 months. So let's just say roughly $110,000 for 1 year for one individual. And who made that payment?

Mr. GOFF. I believe the Department of Public Aid made that payment under a contractual services arrangement with John Simon.

Senator PERCY. And then the ultimate source of those funds would have been part Federal, part State?

Mr. GOFF. I do not know that, Senator.

Senator PERCY. We will want to ascertain that, then. Can any member of the staff testify as to where those funds came from? We would supply that then for the record.

The head of the task force was John Simon. You indicated that his father was a judge and his name was what?

Mr. GOFF. I do not know his father's name. His last name is Simon. I believe he's a judge in the Chicago area.

Senator PERCY. That would be Seymour Simon then?

Mr. GOFF. Possibly.

Senator PERCY. Yes. And I think for the record, because the judges in Cook County are sometimes different from those in Utah or Tennessee, I should note that Mr. Simon worked his way up through the ranks. I can supply this information; I've checked with minority staff as to who the "Simon" was we're talking about. There are a lot of Simons. I want to be certain we aren't talking about the Congressman from the 24th District down in "Little Egypt." We're talking about Seymour Simon who was the 40th ward Democratic committeeman, who was the city alderman from the 40th ward, who became president of the Cook County Board and is now serving as a judge in Cook County.

This is his son John, so, therefore, he is not too far removed from politics. I think it would behoove us to look into this payment and see why the payment of $110,000 was made, and under what authority, and where those funds came from, and so forth.

I have just a few more questions. When did Donald Page Moore tell you not to pursue the investigation of certain individuals?

Mr. GOFF. Donald Page Moore did not tell us directly; a member of his staff told us that, Senator. This was in late November or early December of that year.

Senator PERCY. Who actually told you then? Was it on his behalf and did they say that it was at his direction?

Mr. GOFF. Laura Staples who was working for the Governor's Office of Special Investigations made the threatening statement to a member of my staff. She said at the time that she was quoting James L. Trainor, the director of the department.

Senator PERCY. Who were the individuals that you were told not to pursue?

Mr. GOFF. That's currently under investigation, Senator, if I could decline to answer.

Senator PERCY. You'd rather not comment on that?

Mr. GOFF. At this time I would rather not.

Senator PERCY. Did you report this incident to the proper authorities in Illinois and, if so, what happened?

60-PAGE REPORT SUBMITTED

Mr. GOFF. Yes, I did. The proper authority for me was through our bureaucratic channels. The director of the department received from me shortly after that a 60-page report including full detail of the signed statement. I received a confirming letter of receipt from him about 2 weeks after that and he acknowledged that while he disagreed with the content of the facts or statements involved that he would refer it to a proper investigatory group. I do not know if that has been referred.

Senator PERCY. Who in IDPA Public Information Office was threatened and by whom?

Mr. GOFF. Barbara Wright, by Richard Dunn.

Senator PERCY. By whom?

Mr. GOFF. Richard Dunn.

Senator PERCY. Could you identify Richard Dunn?

Mr. GOFF. He's an investigator for the Governor's Office of Special Investigation.

TASK FORCE'S FINAL REPORT INACCURATE?

Senator PERCY. Could you elaborate on your claim that the Governor's medical payment task force's final report is inaccurate, biased, and totally erroneous? In what ways is it inaccurate, in what ways biased, in what ways totally erroneous?

Mr. GOFF. I have pointed out one example already, Senator, where it's clearly known that two employees, very key employees of the division of medical services in that department were removed from their positions prior to the task force period, immediately prior because of accepting gifts of money from factoring firms, yet the report avoids any statements of impropriety on the department's behalf.

Second, we demonstrated very clearly in our statistical analysis that the factoring firms received a much higher degree of special treatment by the use of overwrite codes and the overwrite code is a system used to allow medical bills to bypass all computer audit and edit checks or specific checks.

There would be no check for duplicate payments, perhaps, no checks for case eligibility. The factoring firms received, I believe, a one-third higher amount of these overwrites than did nonfactors.

Senator PERCY. Mr. Chairman, I'd just like to summarize what I think looks like one of the most serious aspects of this case. An arm of the Congress is the GAO. This is the investigative unit, a unit that we can send in to determine what has happened. We have direct evidence now, sworn testimony that the witness was ordered by the director of IDPA in the late summer and fall of 1974 not to cooperate with the GAO auditors. Our responsibility was to find out what happened to Federal funds, to find out whether they were

being handled properly. We had evidence certainly from the news media that there was fraud, that there was mishandling and mismanagement. So we sent in the GAO.

Now we have an incredible situation. This failure to provide information and this failure to reveal anything to GAO made it seem that the State actually did have a better management program and system for uncovering and detecting fraud than it appeared. This failure made our system and our management appear to be worse than it actually was.

Fraud "Covered Up" by Poor Management?

There was a willingness, apparently, to have it shown and demonstrated that there was poor management which wasn't apparently much of a crime in the eyes of the officials involved in order that the auditors would not know and discover that there was fraud.

So we had a coverup to prevent the discovery of a coverup here and a willingness to take a minor rap in order to somehow evade detection of a much greater offense.

I will be most interested in the testimony and I think we should ask for testimony to be offered in contravention of what Mr. Goff has said as soon as possible. We are appreciative to you for being here. This is not an easy position for you. We'll certainly reserve judgment as a committee and I will reserve judgment as an individual but based on your testimony I can't evidence anything but outrage. Somehow with the oversight responsibilities that the Congress of the United States clearly has, it would be derelict in its duties if, having been placed on notice, it did not use its power to determine what has been happening, that these oversight responsibilities have allegedly been subverted by a coverup. To make this entirely bipartisan, I'm asking Senator Stevenson—and I have reason to believe that he will now concur—that we request and direct Mr. Staats, as the Comptroller General of the United States, to once again review what has been happening, to look now at these new allegations and request that the GAO immediately undertake a followup investigation of the Illinois medicaid program with particular emphasis on these charges that efforts were made to impede the earlier investigation.

Now that they are on notice that there was an attempt to keep from them certain pertinent and vital information, I trust the GAO will be very diligent in uncovering everything and turning over every single stone until we get the full knowledge about this matter.

Senator Moss. The Senator from Tennessee?

Senator Brock. I have one more question along this line. One of the most discouraging parts of your statement was what was just referred to by Senator Percy. I'm not relating now to the actions of State officials but the actions of Federal officials. On page 4 of your statement, you cite HEW, General Accounting Office, and agricultural auditors. The Department of Agriculture apparently pursued to a rather fruitful conclusion in its investigation?

Mr. Goff. Yes.

Senator Brock. Regardless of the impediments being placed in their path?

Mr. Goff. Yes.

Senator Brock. The General Accounting Office said they couldn't put a handle on it because of the complexity and the politics. Their report reflects only what they were allowed to see.

Mr. Goff. Yes.

Senator Brock. Apparently then, HEW regional offices aren't very persistent people.

Now, do you have any indication that these Federal agencies were asked not to pursue the investigation or were encouraged to pursue other areas for their studies?

Mr. Goff. I can recall nothing on that other than what I've testified to.

Senator Brock. It's just difficult to believe that you've got three different agencies in the Government; one apparently does a good job and the other two are doing an inadequate job. Certainly, as Senator Percy has pointed out, the General Accounting Office is a superb institution which has done remarkably good work in a lot of fields and I'm surprised, frankly, that they didn't pursue this regardless of the complexities or politics. That isn't something they're supposed to worry about; they're supposed to get to the problem. I just wonder if you had any indications as to why they did it——

Medical Fraud Difficult to Investigate

Mr. Goff. No. I have talked with them during that time, and after that time, and I don't mean to apologize for them, but medical fraud is a very sophisticated and technical area.

Senator Brock. I understand that.

Mr. Goff. Very often staff that are initiated in that are lost for several months. The Illinois program is very large and very complex and I personally believe they felt they did not have, aside from enough information, enough time.

Senator Brock. Perhaps Mr. Chairman, it would be well to inquire of the General Accounting Office, specifically, and HEW, as to the reason why they lacked staff. Maybe we'd better supply them with some more or maybe they need more specific authorization. I'd like to know on their part what the problem was, if in fact, this testimony——

Senator Moss. We will pursue that further. GAO has given us information on this in the first place. This is sort of a carry-on from when we first learned about the factoring business that goes on in Illinois. We will pursue these issues through GAO. We will also, as Senator Percy has requested, set a hearing at an early possible date. If the Governor feels that this testimony may be biased or inaccurate and wishes to appear or send a representative to tell his side of it, we want to give them full access of the committee.

I do appreciate your coming, Mr. Goff, and giving your testimony. As I said before, I think you've shown considerable fortitude and courage to come in and testify so that we may find out what is going on and what's going amiss in this field of medicare and medicaid payments.

Counsel has one question he wants to ask.

Mr. HALAMANDARIS. I think you can hear me. I'd like for you to state for the record specifically some of the computer runs that were withheld from the General Accounting Office and what they mean. For example, you mentionad the duplicates list a while ago. Can you give us a list of these? Also, I remember you were talking about address clusters and vendor profiles. I'd like it stated for the record exactly a list of the four or five computer runs that would be significant and helpful to those who are investigating fraud.

COMPUTERS AID IN PREVENTING DUPLICATIONS

Mr. GOFF. I can. I'll try from my memory. The General Accounting Office already has a list of these; I had a meeting with them yesterday. Besides the duplicate, there's a vendor-duplicates report that's computer run M–005, which lists multiple services, duplicate services to the same recipient on the same day by more than one vendor.

Mr. HALAMANDARIS. In other words, if you had your appendix taken out in four or five clinics in the city during 1 day the computer would pick it up?

Mr. GOFF. Yes; That's right. Also, there is a group of computer runs, M–510, I believe, and M–514, a series of four runs that are specific procedure code profiles.

For instance, your point about the appendix would also show on one of those runs. In this series of computer runs, there are specific time parameters or surgical operations that can occur only once. They are listed in the computer and vendors which by that procedure would then be listed out on those. There is an additional report which is called the "vendor profile" which lists maybe 20 to 30 specific variables on any particular vendor. His average speed of payment, what type of cases he's handling, and the type of procedure codes that he uses. It provides a very helpful run in auditing or investigating.

Mr. HALAMANDARIS. What about address clusters? What's the significance of that?

Mr. GOFF. The address cluster was one of the first runs developed by my staff. We were told that there were 11 factoring firms operating in Illinois. I did an address cluster; it shows the amount of payments due—any number of addresses. When we were done with that, we found over 34 factoring firms operating.

Mr. HALAMANDARIS. Who told you there were 11?

Mr. GOFF. Robert Wessel. I believe at that time he was the deputy director of the division of medical services.

Senator MOSS. Thank you, Mr. Goff. We do appreciate your appearance and your testimony. We'll now call Mr. Donald R. Hoffman, Topeka, Kans., chief assistant attorney general, Consumer Protection Division; and Mr. Harry G. Wiles III, assistant attorney general, State of Kansas.

We welcome you gentlemen to the committee. I'll ask that there be order in the hearing room. If you want to converse, please leave the room. Mr. Hoffman, you may proceed.

STATEMENT OF DONALD R. HOFFMAN, TOPEKA, KANS., CHIEF ASSISTANT ATTORNEY GENERAL, CONSUMER PROTECTION DIVISION; ACCOMPANIED BY HARRY G. WILLIS III, ASSISTANT ATTORNEY GENERAL, STATE OF KANSAS

Mr. HOFFMAN. Thank you, Mr. Chairman. Attorney general Schneider sends his best wishes and appreciation to the committee for inviting us to appear and the courtesy that you've shown.

My name is Donald R. Hoffman, chief assistant attorney general for the State of Kansas. With me is Mr. Harry Wiles, assistant attorney general from our Consumer Protection Division.

At the outset I'd like to say it was this committee's work and the interest that prompted us in the State of Kansas to take a look at the nursing home situation in our State. For the past 5 years, our office has received a steady stream of correspondence touching on conditions in nursing homes throughout the State.

Sadly, our day-to-day operations in the more traditional field of the work of the attorney general has kept us out of the nursing home area in any meaningful way.

Our State, as many other States in the United States, has what appears to be a rather sophisticated regulatory scheme for the administration and supervision of nursing homes.

For example, in our State, the Department of Social and Rehabilitation Services is the recipient State agency for Federal funds under the medicaid program. The department, as such, exercises supervision over nursing homes in which medicare recipients reside. This department, however, has virtually no staff to actually inspect nursing homes.

SIX NURSES INSPECT ALL HOMES IN STATE

It accepts the certification by the Department of Health and Environment as sufficient for the handling and the auditing of medicaid money. Health and environment in turn relies on some six nurses employed to inspect all homes across the State. There are presently 363 homes in the State of Kansas and as the Senator knows, our State is geographically rather large.

These nurses do not audit nursing homes in any way, thus, for example, personal accounts of medicare residents are never checked. As to private pay residents, the Department of Health is responsible for checking the accounts of private paying patients who are not utilizing medicaid.

The department as it is presently configured, has virtually no capacity to conduct field audits short of the nurses who actually visit the homes.

SRS is utilizing what is known as a "desk audit" technique which is based upon a form filled out by the home administrator himself. No cross check of tax records or other relevant documentation is used.

SRS has one auditor. Only three homes had ever been audited in the field as of August of 1975. Accordingly, Mr. Chairman, I must state that our confidence—I'm speaking for the office of attorney

general—in our State system has in large measure been shaken by what we now know.

We regret that we didn't put our foot in the water years ago. Twenty thousand Kansans reside in these homes. We have done much more in our office for far fewer people than what we have done to date for the elderly. As a group, they are perhaps the ones easiest to overlook.

After our initial contacts with this committee in February of 1975, the legal staff set about to arrange and organize what we hoped to be a cooperative effort with appropriate State agencies. I suppose with this report* and this testimony, that which is not written in the report is about as relevant as what is in the report. From February to near mid-June of 1975, after we advised these agencies that we were going to take a look at nursing homes, we were engaged in what I must describe as an adversary negotiation with the principal State agencies involved in nursing home regulation, the State Department of Health and the Department of Social and Rehabilitation Services.

Agencies Uncooperative

Both agencies appeared to be affronted by our interest in nursing homes. We were asked under what authority we intended to proceed. We were asked to provide a detailed laundry list of what we were looking for. We were promised assistance only if we agreed to keep the fact of our inquiry confidential and when the somewhat hostile nature of our relationship with these agencies did become known, we were asked thereafter to have assistants in our office clear all statements, actions, and reports through personnel of these agencies.

We emphatically refused to do that. We were told that the horror stories substantiated by this committee's work existed only on the east coast or otherwise from our State of Kansas.

We were further told that anything we needed to know about nursing homes could be found in the files of the agency and that we needed to look no further for information. Later, members of our staff were advised that they would have no further direct communications with the agencies and any communication that was had would be on a personal one-to-one basis with the attorney general himself. When it did become apparent that Attorney General Schneider, with or without any agency assistance, would actually go into the homes and further his investigation, we once again became involved in some elaborate high-level negotiations generally described more in the nature of a hassle.

Personnel from the agencies, we were advised, could only accompany our staff if the agency were advised 1 full week in advance of the exact homes and locations we intended to inspect. Frankly, this was the demand that broke the camel's back. Our office decided to proceed on our own.

In light of this background and the delay that it caused, I think it is safe to say that if we went into the matter with any bias at all, it was in favor of finding no problems in Kansas nursing homes.

*See appendix, p. 275.

At that juncture, it would have been much easier for us to have found no problems and gone back to our traditional workload.

This was made impossible by the findings that we made in the homes visited by our staff which in actuality forms the basis of the initial report* that you have in front of you. We selected eight homes. They were selected because they were suspect of abuses but in apparent good standing with State regulatory agencies and located in communities with local resources for inspection other than the State. We were interested in seeing how bad a Kansas nursing home could be and still operate uninhibited by regulations. All homes were normal in that approximately 50 percent of the residents were welfare recipients thus both the Health Department and SRS would have responsibility to the home and to its residents.

As a general statement, I might summarize some of our findings. Generally, up-to-date accounting records were uniformly unavailable in all of the homes. In one home, residents' personal funds appeared to be commingled with the home's general operating fund.

In one home, individual accounts were being charged for talcum powder, hospital gowns, soap, and other materials which we regarded as part of the usual and ordinary daily charge of the home and should not have been charged to personal accounts.

Not one home inspected had health certificates for all employees as required by regulation, both Federal and State. The best home had certificates for employees but none for those hired within 2 or 3 months of the inspection. In one home, 25 of the 38 employees had no certificate at all, and in another home, 12 of 21 had no certificates.

Written Policy Standards Unavailable

We found that written policies and procedure required both by State and Federal regulations governing the service provided by the facility and intended to provide the public and residents with consumer information were not functionally available within the homes as required. It appeared rather patently that the policy statements which are in fact a consumer-oriented requirement were done merely as a formality to get the homes through any inspection that might have occurred.

Most of the time, the standards were unassembled and unavailable. We found absolutely no evidence of in-home educational programs in any of the homes for the personnel, yet uniformly personnel turnovers for these homes was high.

Fire exits were tied shut with sheet and wire in one home off a long hallway where handicapped residents live. I have a picture of that. We didn't provide it on our report. I would be most happy to give to your committee a Polaroid copy. We found no evidence of brutal restraints being placed on residents but we had a number of reports that that was the case in homes. We found that oxygen was stored in unlocked closets in one home.

Regulations require that it be secured in an accessible location. Fires in Kansas nursing homes are comparable with the national average on statistics of fires in nursing homes.

*See appendix, p. 275.

Every home was in violation of basic regulations relating to the storage and dispensing of narcotics and drugs. Every home was in violation of the basic regulations relating to the compilation of drug records.

In every home, it was patently obvious that nonlicensed, unqualified personnel, even residents themselves could attain access to drugs and narcotics. We found that pill counts were not made. Records that were kept did not correlate with records of dispensing of drugs.

Only two homes reported any drug waste at all, that is, drugs lost through droppage or spillage. This is almost an incredible or phenomenal record, if correct, but it's hardly believable.

Clear evidence of drug borrowing by nurses, dispensing drugs, was found. That is borrowing from one resident to give to another for whom it was not prescribed. Retention of drugs prescribed for deceased residents was evidenced. In one home, the controlling interest was owned by the pharmacist shown to be the only pharmacist filling prescriptions in that home as well as in two other homes in the community.

Six of the homes reeked with the smell of urine, including the dining and food preparation areas. Patients confined to bed smelled of urine. Patients were found to be wet. No social activities were scheduled or planned for residents in most of the homes.

One-half of the homes did not provide soap and soap dishes for each resident. Denture equipment was lacking or inadequate. None of the homes provided enough towels and washcloths for each resident. Washcloths and bedding were often rags.

Drugs Prescribed, Not Dispensed

We found direct evidence that drugs were being prescribed by a doctor but were not dispensed. One patient was found to be a diabetic but his last reported blood sugar test was in October of 1973.

We found outdated drugs. We found drugs not dispensed according to the schedule and at intervals prescribed by the doctor. In some cases, drugs were dispensed 2 or 3 hours off the prescribed dosage schedule.

Medicine vials were found to be used and reused without sterilization. We found strong disinfectants, bleaches, and rubbing alcohol in areas totally accessible to the residents or anybody else who wanted to have access to them.

Nursing records were poor to nonexistent. In one home, there was evidence of a catheter not being changed or cleaned for several months and there was no recollection that it had ever been changed.

Commingled drugs were found; some drugs prescribed for one patient were found on a shelf nearest the resident's roommate. Insufficient numbers of blankets, sheets, and plllowcases were found to be uniformly the case in all the nursing homes that were entered. Bathtubs and showers lacked rubber floormats for the patient. Men and women often used the same restroom. In one case, they were using the same restroom and the other restroom was used for storage.

We found in one-half of the homes the required therapy room which is required for a level of nursing homes, were used for storage as opposed to therapy.

In one home, we found a welfare recipient whose personal account had been allowed to balloon to over $900. This is based, as the committee knows, on the $25 per month basis. We found no evidence and there was no recollection that any expenditure had ever been made on behalf of this woman for personal comfort or entertainment items and the administrator himself could not recollect any of those items being given to the lady.

I think that's a highlighted summary of the report* that the committee has laid in front of you. Subsequent to the publication of this document, we have testified in our own State before several committees studying nursing homes.

The subject of nursing homes is of great importance to the legislature in Kansas. I am confident that there are going to be some positive results from our report. Cooperation that was lacking in the early going between the two agencies that were primarily involved now appears to be forthcoming.

Subsequent to the issuance of our report, the two major agencies went back to the very same homes that we had gone into. I think the attempt was to shoot our report down with respect to some of its findings.

They were generally in accord with the findings that we had made and as a result of that, they have submitted a rather elaborate proposal to the legislature for corrective action.

Need: On-Site Inspection

As a general statement, the real problem with respect to nursing home regulation in our State boils down to the lack of qualified personnel to go out and actually get into the home. I'm hopeful that this threshold report that we've started will precipitate the placement of sufficient numbers of personnel in the agencies to handle the matter.

Senator Percy [presiding]. I want to thank you, indeed, Mr. Hoffman, for your testimony. You've indicated that violations of laws and regulations go unobserved or unpunished and in most cases observance of many laws in quality establishments is clearly up to the administrator.

Can you comment on why this in your judgment occurs?

Mr. Hoffman. Well, there's absolutely no accountability. As I indicated, they don't inspect these nursing homes in the State. There is no correlation between what the administrator says exists and what in fact does exist because the administrator is allowed to, in effect, audit himself. The regulatory agencies conduct only a desk audit on the form that the administrator provides.

Senator Percy. You indicated in your report that the Department of Social and Rehabilitation Services had only one auditor as of August of this year to cover 367 Kansas nursing homes. Is he or she full time?

Mr. Hoffman. Yes.

Senator Percy. How is it conceivable—I know Kansas runs a tight budget, I suppose—when you're carrying on a program where there

*See appendix, p. 275.

can be such obvious abuse and where you have a department called the Social and Rehabilitation Services, how could anyone conceive of having adequate coverage of 367 nursing homes—and they're scattered around the State?

Mr. HOFFMAN. Yes, sir.

Senator PERCY. All are covered by one investigator, one auditor. How many auditors are now employed, do you know?

Mr. HOFFMAN. Well, they intended to bring on two more.

Senator PERCY. Is there still just one employed?

Mr. HOFFMAN. That's correct.

Senator PERCY. They plan to increase it by 200 percent then?

Mr. HOFFMAN. That's correct.

Senator PERCY. How adequate do you think three auditors will be, when they're on board, compared to one in covering 367 nursing homes?

INSUFFICIENT NUMBER OF AUDITORS

Mr. HOFFMAN. I think it will be a back-breaking effort to get any meaningful auditing done with only three personnel. Of course, there's going to be some startup time getting these people attuned to the problems of rules and regulations and accounting principals in nursing homes, unless they're fortunate enough to hire people that have done this in the past.

Senator PERCY. In the Federal system, we believe in having things done closest to people when they can be done, done by local government rather than State, the State rather than the Federal. But when you have cases where we really place responsibility for supervision, for auditing on the State, and you have a situation where obviously by any rule of thumb, there could not be a reasonable audit in the performance of that function, then doesn't that just invite more Government, more Federal regulation, or Federal control?

Mr. HOFFMAN. I would have to agree with you, Senator, that that's the unfortunate result of State inaction. We've been very active in opposing Federal—what we call encroachment on traditional State functions—but I would have to concede in the area of nursing homes. We have not been doing the job. I did not mean to impune the credibility of these two State agencies that were primarily involved. I think that the reluctance to take an objective look at nursing homes was based somewhat on a natural human response to some outside agency getting involved in something that they have historically not been involved in.

But I think that the report did a great job. It raised some eyebrows and I think an attempt has been made to correct the situation; but the establishments, as you have noted, have only two more auditors and I would say this is most definitely inadequate.

Senator PERCY. Now, auditing can determine and detect a great deal of fraud involving medicare and medicaid and yet we have had relatively few prosecutions. Our figures indicate that less than 1 percent of the reported frauds are actually prosecuted. Can you tell me why, in your judgment, this is the case? Why this kind of a pattern?

Mr. Hoffman. I would have to say that that's not a robbery from a prosecutor's standpoint in the traditional sense. It's the type of thing that many prosecutors would view as a civil problem as opposed to being a criminal problem and I think very candidly that the agencies that are primarily responsible for detecting fraud have not been detecting fraud so they can turn nothing over to the prosecutor to prosecute.

I think we have an excellent record in our State of vigorous prosecution and I'm talking not from the attorney general's office; I'm talking from a local level of prosecution. They do a fantastic job. I think that they will do it if they were presented with the tools from which they could work, but without auditing in a meaningful sense, there's no way that a prosecutor could take such a case into a criminal court.

Senator Percy. Mr. Halamandaris, do you have any questions or Mr. Miller?

Mr. Halamandaris. Mr. Chairman, I have no questions. I would like to compliment these gentlemen on a very fine report and with your permission I'd like to have it entered in the record.

Mr. Hoffman. Thank you.

Senator Percy. Well, I thank you very much, indeed, gentlemen for being with us. We're most grateful to you. Thank you and without objection—there's no one here to object—the report will be entered into the record.*

Our final witness today is Charles Brown, president of the California Pharmaceutical Association in the beautiful city of Santa Barbara, Calif.

We're glad to have you here. Due to the lateness of the hour, and regretfully our chairman has had to leave, you're free to summarize your testimony. If you'd like, and without objection, your entire statement will be incorporated into the record.**

STATEMENT OF CHARLES D. BROWN, R. Ph., PRESIDENT, CALIFORNIA PHARMACEUTICAL ASSOCIATION, SANTA BARBARA, CALIF.

Mr. Brown. I'm Charles Brown, a community pharmacist from Santa Barbara and I am fortunate to be presently serving as president of the State Pharmaceutical Association. I service at the present time about 281 nursing home beds in Santa Barbara.

In the past I've serviced up to a total of 800 nursing home beds. We have been living in a quagmire lately as the pharmacist and nursing home administrators have been receiving poor publicity in regards to some of the arrangements that they have made in order to provide these services.

I will attempt to summarize the testimony. I firmly believe that the relationships between pharmacies and skilled nursing facility

*See appendix, p. 275.
**See p. 267.

and administrators and owners are legitimate. I do not believe that the publicity we've received is in actuality practiced in the majority of the cases. I realize the fact that maybe this doesn't sell news but the problem being is that the majority of us who are providing good services are being looked at with a very jaundiced eye and it's creating a lot of problems for those of us who are giving good services both in nursing home facilities and from pharmacies.

Basically, I'll go into some of the problems that we have, the rebates themselves. Pharmacies have offered them and nursing home administrators have asked for them.

Rebates Solicited

In many cases, the pharmacist is not allowed to service a facility regardless of the type of service that he provides unless he is willing to accommodate either the proprietor or the administrator of that facility. I myself have been approached many, many times and was asked to approach the administrators of several facilities by the nursing staffs because they were not able to get a hold of their pharmacists at night and on the weekends and holidays and so forth.

I was told by the administrator after I had discussed with him the scope of services to be, that I could provide the service if I were willing to give him 25 percent. Now, that money has to come from somewhere.

Mr. Halamandaris. What was that percentage?

Mr. Brown. Twenty-five.

Mr. Halamandaris. Twenty-five percent?

Mr. Brown. That's right. That money has to come from somewhere and the majority of that money comes from private paying or from medicare patients.

The State of California is on a fixed fee basis and there is no way that any pharmacist can be expected to pay 25 percent of this fixed fee plus 25 percent of the cost of the drug to an administrator.

As a result, medicare and private patients are absorbing the 25 percent. With my prepared statement you have a copy of the contract* that existed between a nursing facility and a pharmacist in the State of California. It gives the formula for figuring out exactly how or what the patient will be charged and what the pharmacist will pay back to the facility.

In other areas, we've found that pharmacists are charged storage fees for drugs and one of the problems we have had with that is that in the HEW guidelines for interpretation of the "Prudent Buyer" concept, HEW kind of spells this out directly. It tells about the reimbursement for storage of drugs in a facility.

I think it's absured when a Federal agency will give examples of how a nursing facility may extract funds out of a pharmacy or any other provider to reduce the cost. We have several problems. We would like to correct those problems.

I'm summarizing this so I'm going to find some spots here. Another one of the problems within this situation is that the GAO will make a study and a report will come out and nursing homes and certain

* Retained in committee files.

companies will stand behind that report and will try to force that report on certain providers. I'm speaking of the report that stated that the unit dose medication system should be utilized in long-term care facilities.

When the report came out from the GAO that this should be done. several of the unit dose companies went to the nursing homes and asked them to support the concept. Many pharmacists were approached by the chains and told by one specific chain that they would have to utilize the unit dose system or they would not be able to service the facility any longer.

Unit-Dose System Aids Chain

And ironically that unit dose system had to be leased through a medical supply company owned by the chain. And here again, it is a situation where the Government had stepped forward and made a comment and many pharmacists and many providers were being forced into very difficult positions because of cost, because there was no remuneration coming forth for the unit dose system although they are more effective and are efficient. I utilized this system for several months in four facilities and I think they're terrific systems.

They enhance the medication dispensing facilities in a nursing care home. However, they are expensive and somebody has to pay for them.

The situation we have in California at the present time and this will allude to the Kansas problem also. Under Federal medicare guidelines, nursing homes must retain pharmacy consultants and those pharmacy consultants must review patient medication regimens in the nursing facility.

In California there was no means by which the pharmacist consultant was able to be reimbursed until July of this year. At that time the State instituted a rate of 6.16 cents per patient day to compensate pharmacists for these services.

This means that the average facility in California receives $180 a month to pay for the pharmacist's services. Many facilities are refusing to pay the pharmacist for that service. I know in facilities that I service we have been able to reduce the number of medications by approximately 20 percent by pharmacists' reviewing medication records. Not only that but we've prevented some drug reactions and interactions in certain patients. We found where a patient was allergic to one medication or found the notation on the face of the patient's chart and a physician would be relieving another physician and would order a medication with that particular item in it.

These are some of the problems that we've arrived at, but there is nothing in the State law that requires a facility to reimburse the pharmacist for those services. Therefore, pharmacists are using this as a tool to obtain accounts and nursing facilities are saying, "If you want to retain our account, you wil not ask for this amount, but you will perform the service."

This is a problem because you have ethical individuals trying to perform a needed service and not being reimbursed for it, therefore, you're just sponsoring unethical practices.

As I said before, many administrators and many pharmacists hide behind the "prudent buyer" concept and this creates a lot of problems. I do not believe the pharmacist is necessarily a product provider. They do provide a service and until we separate the two, we are going to remain with this problem.

Prosecutions Necessary to Diminish Abuse

I have been asked to comment on methods of correcting the problem. Public Law 92–603 had no effect on it. I do not know of any administrator or any pharmacist whatsoever that has been prosecuted under this law. I feel that if one or two providers in certain specific areas were to be prosecuted, the practice would diminish considerably.

I feel that professional services have to be reimbursed regardless of whether it's for pharmacy goods, laboratory services, or whatever it is. Any time service is directed though another party, there's an opportunity, to use the word today, for a "rip-off," because the facility will say it's a billing fee, an administrative fee, or whatever they want to utilize so they'll have an excuse for extracting those funds.

Pharmacy services have to be recognized and treated as a professional service and have to be reimbursed accordingly. We have asked for capitation arrangements and we've submitted proposals to both State and Federal government to study the possibility of reimbursing pharmacists on the capitation basis and possibly a capitation for services and the bill for the product will be a separate line item.

Another problem we have and this hasn't been spoken of but skilled nursing facilities have to be reimbursed at a reasonable rate. I stayed in a motel last night and my bill was $39. All I had was a bed to sleep in. How do you justify $19 a day for nursing care when they have to have nursing care 24 hours a day.

Peer review mechanism is another method of controlling the abuses. Individual cases of unethical or questionable practices could be referred to peer review committees and the results of these committees could be forwarded to licensing boards for action.

Peer review has been proven to be effective in pharmacy services. In San Diego, Calif. and in the paid prescriptions pilot projects in six counties in California, it has been shown that pharmacy peer review is an effective tool for preventing abuses. The frustration occurs when cases are referred to State agencies and they work very, very slow or the courts impede any action against the providers.

Meanwhile, the unethical provider makes money and the ethical provider loses business. We feel that severe mandatory penalties along with the complete restitution should be required.

We also feel that the practitioners have to be called in for any type of legislation affecting their profession for their input. In California, pharmacy practitioners were called upon and were instrumental in writing and implementing acceptable progressive regulations. These regulations pertained to pharmaceutical services in skilled nursing facilities.

Good Provider Service Necessary

I feel active provider input is a necessity in any area. I'd like to say that I have really enjoyed servicing nursing homes. I feel I've added something to the nursing care in those facilities. I feel that the majority of my colleagues who are servicing nursing homes have done the same thing.

I also feel that some good publicity has to come out of this committee as to some of those services rendered to patients.

I want to thank you for the opportunity to speak here and I hope that if you need any assistance in drafting any legislation in this area, we would be happy to help you.

Senator Percy. Thank you very much indeed. I believe that based on your testimony you must have foregone and sacrificed financially a great deal in order to get an inner sense of satisfaction and we're very grateful for your testimony.

In 1972, in answer to a subcommitee questionnaire, you indicated that the practice of pharmaceutical rebate was running rampant in California. Is this still the case?

Mr. Brown. Yes, it is; especially in the metropolitan areas.

Senator Percy. You mentioned on page 2 of your prepared statement where you lost an account because you simply failed to match a rebate offer of the 25 percent.

Mr. Brown. Right.

Senator Percy. How many accounts have you lost or is this an isolated case?

Mr. Brown. I have lost five accounts due to the rebate situation, rebate or a billing fee, or the unit dose system.

Senator Percy. What was the monetary value of what you might have thrown away by not matching those? Can you give us any ballpark figures of what your financial sacrifice was by not going along with the prevailing practice?

Mr. Brown. If you want to talk about total volume, I would say about $200,000, total loss of business which produces about a 4-percent net profit.

Senator Percy. I am very pleased that you did go out of your way to state you felt a majority of pharmacy and nursing home relationships are—you called it "nurtured with mutual respect and dependence with the best interest of the patient in mind." I think this subcommittee has always tried to point out that there is a lot of good in the field and we want to focus on that, but our job, our responsibility, is to uproot what is wrong.

What percentage of nursing home accounts would you estimate are obtained under some sort of rebate arrangement?

Estimated 40 Percent Take Rebates

Mr. Brown. I can't speak for everybody. I look at the metropolitan area and I would say probably about 40 percent in those areas. In smaller communities it's much more difficult because the nursing home administrator and proprietor normally are the same individual and they have to face the people every day on the street, and you

don't find this type of situation in smaller areas. I think it's more abundant in the larger metropolitan areas.

Senator PERCY. On page 3 of your statement you refer to a facility which received its medication by Greyhound bus from a pharmacy nearly 100 miles away. Where is that facility located; do you recall?

Mr. BROWN. It was in Santa Barbara. It is no longer owned by the prior operators.

Senator PERCY. On page 4 of your statement you refer to a pharmacy rental arrangement. How common are these dummy rental arrangements?

Mr. BROWN. That basically accounts for, I would say, approximately 20 percent of all of the rebate situations. It's listed in the HEW guidelines where pharmacists may pay for storage of drugs on facilities, which is fairly ridiculous because that should be part of the per diem rate.

Senator PERCY. I would like to try to differentiate between what is a perfectly legitimate discount and what is a rebate or a kickback. Can you describe normal trade practices where you would, yourself, with the ethical standards you have, accept a discount, and where the line is when a discount becomes a rebate or a kickback?

Mr. BROWN. This is difficult. First of all, we have to separate professional services from the product, and being a pharmacist it's very difficult to do this, when you're not receiving any services from an individual, one's purchase volume, depending on the profits that they are making on that volume, the discount will range anywhere from 2 to 10 percent, I would say. But that's with no service.

Senator PERCY. Can you define for us what is unethical in the practices you described and what is clearly illegal and fraudulent?

Mr. BROWN. It's very difficult to differentiate.

Senator PERCY. Well, the 25-percent request for rebate that you received, was that just unethical or was it both unethical and illegal?

Mr. BROWN. According to Public Law 92–603, I don't know the percentage, the specific percentage, but I believe it's unethical, and here again, I believe giving a discount on any professional services is unethical.

Senator PERCY. It has been alleged that recipients under medicaid frequently use their green card at a number of pharmacies on the same day with the same prescription. Have you had any experience with this practice?

OVERUTILIZATION OF DRUGS REVIEWED

Mr. BROWN. In California, they did not have that problem because up until 6 months ago a patient would have two drug stickers and that's all they were allowed without calling for authorization. Since July 1 this is not the case and a patient can pick up prescriptions as long as he can get a physician to write them. We do have peer review committees in California and we are reviewing the overutilization of drugs by the beneficiary, by the provider, and the prescriber.

Senator PERCY. It has been alleged that where drugs have been prescribed, that frequently it is the practice to prescribe the highest

or the most expensive drugs rather than the least expensive. Have you any knowledge of this practice?

Mr. BROWN. In California we do not have that problem. The State establishes a cost ceiling that we can utilize so there is no incentive to use expensive drugs. Under medicare and under private plans, admittedly, there is an incentive to use more expensive drugs if the individual is charging for pharmacy services based on cost plus percentage or a percentage plus a fee. It all depends on how the pharmacist is charging for his fees or his professional services. Our State and national associations are on record of being in favor of a professional fee, independent of the cost of the drug.

Senator PERCY. There have been instances where the patient is not seen frequently by the doctor or sometimes not seen at all, and the pharmacist actually prescribes the medication. Do you know of any cases of this kind?

Mr. BROWN. No, sir.

Senator PERCY. And finally, how frequently are patients' prescriptions reviewed in your own experience?

Mr. BROWN. In our area in the nursing facilities we have to review them on a monthly basis. By law, we have to review the patient's medication records on a monthly basis and write a synopsis of it and suggest any changes in the number of medications utilized.

Senator PERCY. Mr. Brown, I want to thank you very much indeed for appearing here this morning. You have been very helpful to the subcommittee. Your prepared statement will be entered into the record at this point.

[The prepared statement of Mr. Brown follows:]

PREPARED STATEMENT OF CHARLES D. BROWN

I am Charles Brown, a community pharmacist from Santa Barbara, Calif. I received my degree in pharmacy from the University of Colorado. I am presently serving as president of the California Pharmaceutical Assn.

In my pharmacy practice at the Goleta Valley Medical Pharmacy, I service 281 beds in four skilled nursing facilities.

I am grateful for this invitation to testify before this Senate committee to relate personal experiences as well as those of my colleagues relative to our relationships with nursing home administrators and owners and some of their demands for unethical rebates, kickbacks, or other arrangements for payments for referral of patients.

Before I address myself to these issues, I would like to state that I feel that the majority of pharmacy-nursing home relationships are being nurtured with mutual respect and dependence with the best interest of the patient in mind. Ironically, these relationships are very seldom given the publicity our unethical colleagues receive. It is truly a shame, for most are doing a commendable job but are looked at with a jaundiced eye because of the adverse publicity.

I began servicing skilled nursing facilities shortly after I started my pharmacy practice in 1966. I found it rewarding and an opportunity to utilize my education and expertise in the use of medications.

Within a year, I was taking care of nearly 200 beds and 300 residents in retirement facilities. As I offered 24-hour emergency services, I found myself being called to service several other facilities after hours and on holidays because "their pharmacy" was not available after normal store hours. I approached several of the administrators, at the request of the nursing staffs, to discuss the possibility of providing all of the pharmacy services. The administrators and owners would compliment me on my scope of services and voice their appreciation for my assistance when needed. However, unless I

would be willing to comply with the terms being offered by their present supplier they could not consider the change. One facility owner, after I had made a presentation on our scope of services, asked what I would do for him personally. I explained that I felt that our program left little out as far as total services at a reasonable cost was concerned. He then explained that he meant what kind of financial consideration would I give to him outside of the services. I was told that he was receiving a 25-percent rebate at present and that I would have to match that if I wished to service the account. Needless to say I do not service that facility.

Another facility in our area was being serviced by a pharmacy nearly 100 miles away and the medications were shipped to the facility by Greyhound bus. The pharmacy provided the facility with certain consultants and also rented a storage closet in the facility.

One nursing home chain required that all pharmacies servicing their facilities institute a specific unit dose system. That system had to be leased from a medical supply subsidiary of the chain.

Accounts Lost Due to Rebate Refusal

In addition to what I have experienced personally, I would like to relate other kickback examples which some of my colleagues have related to me. Numerous pharmacists have complained of having lost nursing home accounts or not having been able to obtain any contracts with nursing homes due to their refusal to enter into "arrangements" which would benefit the facility's owners or operators.

I have been advised of an arrangement whereby a pharmacist was forced to make monthly payments on real estate purchased by a facility's administrator as a condition of being allowed to provide pharmaceutical services to the patients in the institution. The particular administrator involved in this scheme reportedly stated that the practice was common among the other administrators working for the same chain.

Other pharmacists have informed me that these "rebates" were given in the form of furniture, television sets, leased automobiles, charge cards, and vacation trips. Several pharmacies have been known to pay the salary of an office clerk or staff nurse for the facility.

Payments have been made to the facilities for such items as storage closets, medication rooms, administration of medications, dispensing supplies, billing services, and the list goes as far as one's imagination.

One pharmacy paid rent on a closed pharmacy which had been owned by the nursing home chain at one time. This rent was pro rated according to the number of beds served.

In one Southern California city, a pharmacist and several facility owners and operators went into the "pharmacy business" together. The pharmaceutical services are channeled through the pharmacy and the owners all share in the profits. The greater the prescription volume, the larger the dividends. In this type of arrangement there is little incentive to reduce the amount of medications administered to patients in these facilities.

The provision of medications in a unit dose distribution system has also become a form of kickback. The vast majority of patients in California's long-term care facilities are beneficiaries of the medicaid program which currently allows payment of $2.70 per prescription for the pharmacist's dispensing services. When facilities demand the use of unit dose systems the pharmacist is forced to absorb the additional costs because of the government's fixed fees or face the probability of losing the facility. One interesting point is that many of those willing to provide the free unit-dose systems in order to procure the contracts find themselves out of business due to the costs of the system.

It should be obvious that taxpayers are being required to pay increased costs for nursing home care under the medicaid and medicare programs in order to finance these various questionable schemes.

Additionally, under the medicaid program, where the pharmacist's professional fee is fixed by the government, higher fees are being charged the private sector to once again offset the increased costs caused by the unethical arrangements between the pharmacy and the facility.

I would like to cite a new twist in the kickback arrangement which has recently occurred in California.

On about July 1, 1975, the California Department of Health increased the per diem rate paid to skilled nursing facilities by 6.16 cents per patient per day to compensate for pharmacist consultation services. While the average facility is receiving approximately $180 per month to pay for this service, many facilities are refusing to reimburse the pharmacists for this required service. I might add that this many times becomes a bargaining tool by providers of the service also. In the opinion of many, including HEW's Medical Services Administration, this constitutes another form of a kickback. The Federal and State governments are paying approximately $500,000 annually for a valuable service that pharmacists are required to provide to nursing home patients and staffs, and by and large, that money is not being passed on to the pharmacist's consultant. Obviously if this is allowed to continue, the pharmacists will be compelled to reduce their professional services to the patients and the facilities because of this unethical, greedy practice of providers seeking to enrich themselves at the expense of ethical pharmacy practitioners and quality patient care.

Concept Not Working as Intended

Many administrators and pharmacists hide behind the "prudent buyer" concept included in the medicare regulations. In summary this section states that the facility must purchase its goods and services at the "best discount" commensurate with the volume of business given. The intent of this provision was that the discount be passed on to the patient or other responsible party. This is not practiced in most instances where the discount or rebate system is in practice. It is difficult to understand why the professional services are not recognized and treated as such and the emphasis is placed on the purchase of the product involved.

I have also been asked to remark on possible methods of correcting this unacceptable situation which exists in some areas.

In your questionnaire dated January 23, 1974, you asked if the enactment of Public Law 92–603 relative to penalties for these situations has had any effect on the problem. In my reply dated January 30, 1974, I answered an emphatic NO and that is still the situation.

Since Federal law has not been effective, I feel that local control with the assistance of Federal legislation or regulation might be effective.

I, first of all, feel that all professional services rendered to patients under Federal and State programs must be reimbursed directly to that provider and in a timely manner.

Second, pharmaceutical services must be recognized and treated as a professional service and must be reimbursed accordingly. One suggestion might be to reimburse the pharmacist on a capitation basis for his services to that particular patient. Billing for the commodity supplied would be done as a separate line item at cost. This could be done on a monthly basis.

The peer review mechanism could be another very effective method of controlling these abuses. Individual cases of unethical or questionable practices could be referred to peer review committees with further review of identified problems by a multidisciplinary committee comprised of members from the involved professions plus several public members. The results of the final review would be forwarded to the respective licensing boards for mandated immediate action.

Peer review has been shown to be an effective mechanism in the pharmaceutical profession. The results of pilot studies in San Diego, Calif., and by PAID Prescriptions in six counties in the State of California bolster the effectiveness of peer review on the practice of pharmacy. The frustrations occur when problem cases are referred to State agencies and they work very slowly or the courts are slow to rule and impede the actions against unethical providers. Meanwhile, the fraudulent individual continues to make profits and the honest, ethical provider loses business.

Severe mandatory penalties should be imposed along with complete restitution to the involved parties.

Most legislation in this area is "stop-gap" and proposed to alleviate problems. In California, pharmacy practitioners were called upon and were instrumental in the writing and implementation of acceptable and progressive regulations relative to pharmaceutical services in skilled nursing facilities. I feel that

active provider input is a necessity when Federal and State regulatory agencies propose regulations governing practices in these professional areas.

In closing, I would like to state that I have been privileged in my practice to be accepted as a staff member of the facilities which I service. This relationship has enhanced my abilities to serve the patients and practice my profession and I believe that my services have assisted in improving patient care and the consulting services which we provide have created a decrease in the number of medications being administered to their patients. This is at direct decrease in fees for services performed by myself and my employees.

I thank you for your attention and hope that I have been able to assist the committee in their task.

Senator PERCY. I would like to ask counsel, we had one other witness scheduled who has now decided not to testify, and that witness is a pharmacist whose name has been withheld at his particular request. We have taken a deposition this morning, a sworn statement taken by the staff, and without objection, we will incorporate it in the record at this point.

[The statement referred to follows:]

STATEMENT OF AN ILLINOIS PHARMACIST (NAME WITHHELD)

[Through the cooperation of the State of Illinois Legislative Advisory Committee, the subcommittee staff was able to interview an Illinois pharmacist whose sworn testimony follows below. While providing confidential testimony to both the subcommittee and the Illinois committee, he refused to make a public appearance for fear of reprisals against his life.]

Question. You have the right to remain silent. You do not have to talk to me unless you want to do so. Do you understand that?

Answer. Yes.

Question. If you do want to talk to me I must advise you that whatever you may say can be used or will be used as evidence against you in any court. Do you understand that?

Answer. Yes.

Question. You have the right to consult with a lawyer and have a lawyer present with you while you are being questioned. Do you understand that?

Answer. Yes.

Question. If you want a lawyer but are unable to pay for one, a lawyer will be appointed to represent you free of any cost of you. Do you understand that?

Answer. Yes.

Question. Knowing these rights, do you want to talk to me without having a lawyer present?

Answer. I do.

Question. You may stop talking to me at any time and you may also demand a lawyer at any time. Do you understand that?

Answer. Yes.

Question. Upon that, would you raise your right hand to be sworn. Do you solemnly swear by the Everliving God that the testimony you are about to give today will be the truth, the whole truth, and nothing but the truth?

Answer. I do.

Question. Would you like to proceed to make your statement.

Answer. This is in reference to medical services under the public aid program in the State Illinois. Specifically, my testimony is designed to show possible fraud and overutilization of the medical services which are now supplied by the Department of Public Aid in the State of Illinois. I can show and I have seen it done where one patient can generate revenue for the medical facility in upwards of $250. We will assume patient "X" comes into a clinic with a green card. You all understand what a green card is. The green card number in this case is not a 07 or a 97. The patient comes in with a complaint. He or she wants to see the doctor. They receive them, process their papers, they do see the doctor, the doctor evaluates and makes a diagnosis. In any event, writes prescriptions and drug orders and laboratory orders and X–ray orders and the patient returns to the waiting room to get their prescriptions filled.

In the process, we are talking, if you'll excuse the expression, of people who are in a lower socioeconomic class. They finish their medical treatment that they came in for and they are immediately asked if they want to see the dentist, the eye doctor, the foot doctor, the chiropractor, any of the health providing services that are in this particular unit and they make a trip from one to the other like a round robin, or in a, what would you say, a merry-go-round situation. The patient is really unaware that they are being manipulated and they're very careful about telling them they must go see, they just say, "Well, if you've got time you can see so and so," and they do. They haven't got anything to do anyway, most of them are on as I say, public aid or relief, and their time is their own. Now, when you get to actual fraud involved, it's very easy to dispense 20 doses of a medication and increase the dose when you bill the State to 30 or 40. It's a simple matter to do this and I'll show you graphically how it's done. The doctor himself may not even be aware that they are increasing the amount of laboratory work involved. He may order a urinalysis and a blood chemistry. If you are not familiar with medical terminology or the way laboratory sheets are set up—it's a system of boxes and X's. So he checks two and the firm or individual who is in charge of this checks six, you have increased the amount of laboratory work by six times. Where a urinalysis and a blood chemistry test will run roughly $20, if you check additional boxes on this check list, you'll run it up to $150.

Question. Are you aware of any laboratories that check these extra boxes and bill the State of Illinois for the services that they have rendered?

Answer. Yes, I might qualify that and say that the laboratories themselves are aware of it. They do not actually do the fraud involved. They get the order and whatever is marked, they do. It is done at the clinic level.

Question. All right. I am sorry to have interrupted you. Proceed.

Answer. Let us take a typical case and say that the original examination, comprehensive history and so forth is billed to the State for $35 which is a legitimate fee. I am talking about the doctor's papers. The prescription volume is generated there, they try to reach a level of 8 or 9 or 10. If you take the average price of prescriptions it runs $50 and if you take the average cost of this medication you are talking about $30. If you, as a private individual, went to your physician and he wrote up a couple of laboratory requests and 8 or 10 prescriptions, you would think he was out of his mind. If you get two you are surprised.

There are so many things running through my mind and I probably could answer questions at this point more directly than trying to roll out my thoughts.

Question. It has been alleged that there are some clinic owners who employ physicians to do nothing but fill out paper. These physicians never actually see patients. Are you aware of this practice?

Answer. Yes.

Question. Can you describe it?

Answer. I can put it this way, the physician is licensed, he is on the premises and probably the only time he sees the patient is when the patient walks by him either to the lab or pharmacy. He never actually puts his hands, as they say in medical terminology, laying on of the hands, the patient is actually serviced by perhaps unlicensed physicians, immigrants, they are physicians in their own country but do not have a license in the State of Illinois. I understand that as of now we do have a physician's assistant program in the State of Illinois, but prior to this date we did not, so you might say that these people were in violation of the medical practice act at that point. At this point, I don't know the legal setup of this, so I can't comment. But they were really being treated by unlicensed personnel. Mind you, I'm not saying untrained, I'm saying unlicensed. Those people, the unlicensed personnel, could not sign directly these papers so they had to have a licensed physician to do so.

Question. And the only real function of the physician was to validate the form?

Answer. They were hiring his license is what it amounts to.

Question. It has also been alleged that some clinic owners simply bill the State using a list of green card numbers. In other words, it isn't even required that the patient come in. Do you have any awareness of that practice?

Answer. Not in my experience at this point. No, that is not valid as far as I'm concerned. It might be true, but not in my experience.

Question. In your experience, have you seen assembly line treatment to entire family units? In other words, really one member of the family is sick. Three or four additional members happen to be with that relative and the clinic then treats everybody in the family.

Answer. Absolutely. The more volume, the more money it amounts to. The mother might be the prime patient, but they'll encourage them with "When has the youngster had his last shots, or has he seen the doctor lately or the dentist, etc.", and usually it's been . . . it's free, let's face it, something for nothing so it's sure, take Susie in or John, or what have you.

Question. Can you describe some of the practices in terms of pricing of drugs or the kinds of drugs that are being dispensed and what abuses might exist there?

Answer. Qualify that, by saying that prior to August 1 of this year, I was encouraged to write the most expensive type of antibiotics if they were indicated. For instance, upper respiratory infections can usually be treated by three major antibiotics: penicillin, tetracycline, and a relatively new drug called vibramycin or erytaromycin. Now, the most expensive of those four that I mentioned is vibramycin and invariably, that would be the one that would be used to treat this particular case. I'm not criticizing the doctors choice of drugs, I'm just saying that if you had these four laid out here and that there were no contradictions, medically, 9 times out of 10 they would use vibramycin as a drug of choice to treat this particular type of infection.

Question. Do you have any knowledge of abusive practices which are geared to cheat on the number of pills dispensed or an attempt to duplicate the prescription so as to duplicate the professional fee or anything of that sort?

Answer. Yes, I thought I may give you an example. Suppose the prescription order calls for 100 vitamins and the dose on vitamins is usually 2 or 3 a day, so this would be a normal month's supply. The patient hands over the prescription to the pharmacy for dispensing and instead of getting 100 they only get 50. This is strictly an example, but it does happen and the State gets billed for 100. Does that answer your question, sir?

Question. Yes. Are you aware of any drug trafficking at the expense of the department of public aid?

Answer. Absolutely, in this case, however, the trafficking at the erpense of the State is solely on the shoulders of the green card recipient. And I'll explain to you how this comes about. Let's say that this particular individual is a 07 classification, which means he or she is probably under some kind of drug rehabilitation program in the first place. One of the most common drugs used to get these people out of the office and quit cluttering up the scene by any practitioner is either librium or valium, sometimes doriden or placidyl. This is what they are looking for, they're looking for downers. I'm talking about the recipient now. The practitioner usually only gives a nominal supply of 10, 20, 30. This, if you are talking about valium, 10 milligram, on the street is worth anywhere between 25 and 50 cents a dose. These people are very smart, by the way, they know all the colors and all the shapes and the strengths better than I do and I practice with it every day. They also know how to count and if the prescription calls for 20 and you give them 19, boy, they are right there. You forgot one, you cheated me. Maybe you did, not intentionally, but it's pretty easy to miss one pill. They don't miss one pill. You are through with them. You fill the prescription and the doctor's seen them. They turn around and go up the street to the next clinic. They turn in the same card and there is no way of checking that they were here or there or elsewhere. They make six clinics in 1 day. I overheard one patient, I don't remember the name now, saying they had been to seven. They just make a routine of it and they come out with a bag full of goodies from every one of them.

Question. To your direct knowledge, is it common practice for a pharmacy to bill for a trade name medication and dispense a generic on their own initiative?

Answer. Yes, the Department of Public Aid manual, which really gives you a listing and a cost in many cases of the different drugs that are allowed is supposed to control this but in effect what it does is place a ceiling or a price ceiling on costs, so if the pharmacist can buy the same drug at a lower cost, then that's the one he is going to buy but the State gets billed for the

one that's in the manual. The difference in price between drugs, we'll take vibramycin. If you buy it direct, I believe it's approximately 66 cents a capsule. You can buy a generic form of vibramycin and it runs you about 44 cents a capsule, but when you bill the State, of course, you bill them at the 66-cent price. In business ethics, this is legal and logical and moral because you are buying something at a lower price than what they are going to pay for and you pocket the difference. It makes good business sense.

Question. To your knowledge has the State audited acquisition costs?

Answer. I've never seen any hint of an audit of acquisition costs and I've been in this State since 1952. I've never seen it happen.

Question. What is your opinion of the formulary?

Answer. If you want my frank opinion, I think it's rather assinine. The formulary, in my opinion, does nothing to control costs. It does limit the legitimate prescriber and dispensers field of choice and it doesn't do a thing except perhaps create a lot of patronage jobs in the State of Illinois, which I understand is on the verge of bankruptcy. Now maybe this would be a good time to knock it out. We can refer to our neighboring State of Indiana which does not have the formulary and in that State anything that is written by the physician or the practitioner is allowed and then the fee is added onto the cost of whatever the particular merchandise is. I might add that they do not allow a lot of the over-the-counter things that we do.

Question. Sir, your occupation is a registered pharmacist in the State of Illinois. Is that correct?

Answer. Yes.

Question. How long have you been a licensed pharmacist in the State of Illinois?

Answer. Approximately 23 years.

Question. During that time, you have worked in high-volume public aid pharmacies?

Answer. Yes.

Question. And also in, shall we say, green card clinics?

Answer. Yes.

Question. And during the time that you were employed in the green card clinics do you have any personal knowledge of the connection between the owners of the clinics, doctors, pharmacists, laboratories, and so forth?

Answer. Yes. Perhaps by giving you an example of an operation, perhaps this would explain it easier. The physician is, of course, the most important factor in the operation of one of these clinics. He is a hired contract physician. As anyone knows, if you hire somebody, they are your economic servant, so to speak. It behooves the contract physician to produce for the firm and in the case of medicine and pharmacy, the easiest way to produce is to issue or generate prescription writing. Now, I think a good example would be a private patient seeing his private physician might end up with two, possibly three prescriptions per office visit. The average with the green card clinic is anywhere from 6 to 10 per patient. These people may need all this stuff, but the way the system is set up it encourages over-utilization of drugs and services. There is a financial interest, either direct or indirect with the suppliers of other medical services, such as laboratory work. Now the State of Illinois, we will assume, the State of Illinois is being billed for $1,000 worth of laboratory procedures. By the way, I must say that they really do these things. Some of these labs are really right up to date. They've got all of these master computers and machines that will take a sample of blood and run umpteen tests on it in a matter of seconds and it will give a printout and states the name, blood type, and the whole bit and they can do it in less than a minute. Of course, when you are getting into computer operation everybody should know that when the machine is idle, it's costing money, when it's running, you're making money. So the more tests they run, the more money they can make. So to get back to my original thesis, we will assume that the lab is billing the State for $1,000 worth of laboratory tests, which according to the manual of the procedure is correct. The clinic who initiates this laboratory work will get a rebate, I can't prove that there is a rebate but I know how it's done. Of anywhere from 20 to 40 percent of the total billing is rebated. So if you're talking about $1,000, $400 is coming back to the clinic. This is revenue from that patient. I'm talking about. The labs get around this, how shall I say, with unethical business practices. And this is one of the ways they do it. Instead of giving

you a direct rebate, they'll put the receptionist on their payroll and pay her salary and in addition to that, of course, there is a hidden salary that goes to the firm. This also means that the clinic doesn't have to worry about salary costs for at least 1 or 2 people. They can cover this by putting, let's say an X-ray machine, that's rather expensive, but it's done, or an EKG machine, they'll put an EKG machine in the clinic and the girls operate it and they rent the space from the clinic to cover the cost of the rebate.

Question. Insofar as the contract physicians are concerned, what are they usually paid, in what range?

Answer. Between $700 and $1,200 a week. This is what I have been able to see and determine on my own in my experience.

Question. And this is a gross check?

Answer. A gross check, without deductions.

Questions. Insofar as the relationship between the pharmacist and the other medical practitioners in the green card clinics, would you like to comment on that?

Answer. In most cases, it's relatively minor or nonexistent. In a few there is a good rapport between the practitioners and the pharmacist. Generally, each practitioner with a license in the clinic does his own thing and very seldom consults or refers to the other practitioner in the same clinic, except on rare occasions.

Question. Are there any other abuses that come to your mind insofar as the clinics are concerned or the pharmaceutical industry is concerned?

Answer. Yes, I would say it's over-utilization perhaps, or maybe that is not a good term, whatever it is, I'll give you an example of a situation that happened just recently. Working in one of these clinics downtown in Chicago, if I did not have valium, doridin, talwin, mylanta, and listerine, I couldn't practice pharmacy or perhaps the doctor couldn't practice medicine because that's all that we dispensed in that period of time, those five items. Every patient got all or some fraction of them. If you took that out of the medical armamenterium, the patient would either not do well or the doctor couldn't practice medicine or we couldn't practice pharmacy.

Question. What was the average number of prescriptions given to a recipient when they would go into the clinic?

Answer. At least 4, and usually 8 to 12.

Question. I think that you've been very helpful to myself and to the committee. I have specifically avoided asking you any specific names, addresses, places, and so forth for your own protection. I assume that you would be willing in the future to go into more detail with one of our investigators if the situation did arise to give us some specific names and locations and other information so that we could proceed. Is that correct?

Answer. Yes. I would be delighted to, sir.

Question. On behalf of the legislative advisory committee on public aid, I want to thank you for voluntarily coming out here this morning and informing us of some of your own personal experiences.

Answer. Thank you, Senator.

Senator PERCY. The statement simply indicates the kinds of practices a pharmacist in Illinois saw particularly in public aid cases and the use of the green card, an assembly line operation whereby the patient comes in with nothing else to do is routed around to various physicians. The government then pays. The pharmacist did not want to reveal himself. We have his sworn statement, and his testimony was taken by whom?

Mr. HALAMANDARIS. By State Senator Don Moore from your State, but others were present as well.

Senator PERCY. The hearing is adjourned, and there will be other hearings.

[Whereupon, at 12:55 the hearing was adjourned.]

APPENDIX

SPECIAL INVESTIGATIVE REPORT, "THE NURSING HOME INDUSTRY IN KANSAS"; SUBMITTED BY DONALD R. HOFFMAN,[1] CHIEF ASSISTANT ATTORNEY GENERAL, STATE OF KANSAS

Introduction

The Consumer Protection Division of the Kansas attorney general's office, prompted by private complaints and the national concern over nursing home industry abuses, has initiated an investigation of nursing home practices in Kansas. The purpose of this investigation is not to prosecute the individual establishments investigated, although the Department of Health and Environment or the Department of Social and Rehabilitation Services may choose to take action upon the information provided. The purpose is to compile information enough to ascertain the actual conditions existing in Kansas nursing homes and whether these conditions conform to those required by law and agency regulations. If conditions are found not to conform, the purpose is to expose the need for more efficient enforcement procedures. If conditions do conform, it will be necessary to determine whether, in actual practice, present regulations are sufficient to protect the mental and physical health and safety of approximately 20,000 Kansas citizens residing in nursing homes.

The Kansas Attorney General's investigation began with the reports of the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging. These reports are based upon 15 years of fact gathering, 35 hearings, and some 5,000 pages of testimony. A summary of major points in supporting papers upon the topic, "Nursing Home Care in the United States: Failure in Public Policy," have been retained in the committee files. It is sufficient here to say evidence was found to support the committee's statement that the most important nursing home abuses listed in the papers "* * * are far from 'isolated instances.'"

On Tuesday, February 4, 1975, Harry G. Wiles II, of the Consumer Protection Division met in Washington, D.C., with Mr. Val Halamandaris, associate counsel for the Senate Special Committee on Aging. Mr. Halamandaris advised Mr. Wiles upon which aspects of nursing home care could be most effectively investigated within the budget of a State agency, and which would best coordinate with the nationwide efforts of the Senate subcommittee. Mr. Wiles agreed to submit results of the Kansas investigation, when completed, to the Senate Subcommittee on Long-Term Care.

The attorney general's staff then requested State and Federal laws and agency regulations applicable to Kansas nursing homes. The various State agencies having authority over certain aspects of nursing home operations were consulted as to their standards and methods of inspection. The Department of Health and Environment, the licensing agency for Kansas nursing homes, allowed the attorney general to examine its files dealing with citizens' complaints as to nursing homes and results of routine nursing home inspections. Officials of the Department of Social and Rehabilitation Services were questioned as to accounting procedures in regard to Federal-State medicaid funds and disbursements.

With information gained from the above research as to what nursing home conditions should be, check lists were made of minimum legal requirements as to the physical plant, patient care, accounting procedures, and drug administration procedures. Using these lists, a team of eight persons, consisting of an accountant, a registered nurse, two attorneys with the Con-

[1] See statement, p. 255.

sumer Protection Division, one secretary, two investigators, and a legal assistant, made unannounced inspections of eight nursing homes in the State. Several of these nursing homes were chosen because of complaints about them received by the attorney general and the rest were picked at random.

The results of this research and investigation are set out below. All information compiled indicating illegalities existing have been set forth, documented and referred to appropriate State agencies for action. As stated above, the purpose of this investigation is not to prosecute a few establishments, it is to enable an informed attorney general to recommend legislation and enforcement procedures which may save thousands of the aged from the exploitation and misery which prompted Senator Frank E. Moss, chairman of Subcommittee on Long-Term Care to state:

"It is hell to be old in this country. The pressures of living in the age of materialism have produced a youth cult in America. Most of us are afraid of getting old. This is because we have made old age in this country a wasteland. It is T. S. Eliot's rats walking on broken glass. It's the nowhere between this life and the great beyond. It is being robbed of your eyesight, your mobility, and even your human dignity."

Nursing Home Conditions Complaints Received

The fact that nursing home abuses do occur in Kansas was first substantiated for the attorney general by the numerous complaints received by this office. A few of the complaints were from patients themselves. Most, however, were evenly divided between concerned relatives of nursing home residents and nursing home employees frustrated by their employment conditions. The nursing home employees who wrote to complain, usually nurses or aides, cited time and again the lack of adequate training or numbers of personnel as the cause of many abuses.

The first area often complained of involved the condition of rooms in which patients must stay. Dirty rooms with filthy floors upon which excrement was allowed to remain, or upon which were strewn the patients' dirty laundry were often cited. Beds and wheelchairs upon which people are confined remain unclean, dirty bathrooms, bedside commodes encrusted with filth, and one man reported filthy dining room chairs and bed railings in his wife's nursing home. Employees wrote in to complain of being supplied with inadequate bedding so they could not change a patient's sheets when such became soiled; or linen which does not fit the beds so patients end up lying on the rubber under sheets as no mattress pads were provided. An aide complained of not enough hospital gowns to change bedwetters. Urine odors in rooms and linens, after supposed cleaning, were not uncommon complaints. Cockroaches and mice were also reported, even in a nursing home in operation less than a year.

Very disturbing revelations were those concerning patient treatment. An employee of one institution related several instances not uncommon in other complaints received. She related the case of one patient incapable of walking who was restrained in a chair each day from 6 a.m. until 9 p.m. or 10 p.m. The patient was never taken to the bathroom or allowed any freedom of movement for independent activity. She was forced to wet and soil herself. Her clothes would then be changed, perhaps hours later, but she was not washed or cleaned. The employee told of another elderly man, left to lie for hours on his soiled bed. She stated, "Many times he would ask me to please not try to wash the dried fecal material off him because it hurt so much." These do not appear to be unusual incidents—a person anonymously wrote in of another institution, "I have seen them (patients) go without proper baths, or have to lay in feces, because he or she new [sic] better, Mr. Schneider, if they new [sic] better or could do better I'm sure they would not want to be in a home."

Another common complaint as to patients treatment is that persons whose conditions require special diets and whose doctors prescribe such, as diabetics for example, are served the same food as others in the home. Surprisingly, it is reported that the food served is sometimes spicy and not easily digestible, as chili or enchiladas for example. Another complaint is that drugged patients are not encouraged or assisted to eat.

Neglect is cited as a major problem in treatment of patients by those writing to the attorney general. There were complaints of bed sores, or sores from sitting in one position all day and not being moved. Patients with various urinary or vaginal infections are said to be neglected, doctors are rarely contacted and, if they are, prescribed treatment may not be followed. A nurse reports bandages are not changed or checked for days at a time. Baths may not be given to a patient for 2 or 3 weeks at a time.

The nursing home in relation to drugs and medicines it must administer patients is a major area of concern. Drugs are a major expense for the nursing home patient, whether he is a private or welfare client, and are an easy area of abuse for the nursing homes. Several relatives of private nursing home patients have complained that their relatives' medicine bills went up upon entering the nursing home. At least one has reported her relative must buy all drugs from a pharmacy owned by the owner of the nursing home. Several nursing homes studied, purchased all drugs from one pharmacy, with the nursing home as middleman between the patient and the pharmacy. As the Senate Subcommittee on Long-Term Care discovered, this creates opportunities for nursing homes to demand kickbacks of up to 25 percent for the business they give a pharmacy. There is no proof of this occurring in Kansas, however, there are enough indications to warrant further investigation.

A too common complaint, from patients' relatives and nursing home employees, is that "troublesome" patients are kept constantly drugged. A woman writes that her mother was given sleeping pills at night, another at 9 a.m. and yet another at 1 p.m. or 2 p.m. A licensed practical nurse related the story of a 47-year-old ambulatory patient who could do almost everything for himself when he entered the nursing home. After 1 month, his speech was slurred, his walk unsteady, and he slept most of the time. It was discovered that an error had been made on the label of his medicine. He was allegedly receiving over three times his prescription order of phenobarbital. A nurse, a nurses aide, and others report seeing personnel not authorized to handle medicine, give unprescribed sedatives to patients in order to "keep them quiet." A nurse tells of one 94-year-old woman kept sedated at all times with librium and valium for over a week because whenever she awakened, she yelled and screamed and seemed very disturbed. Finally, she was taken to the hospital where it was discovered she had a broken hip. No one knew how or when she received it.

Other complaints indicate a general sloppiness in the administration of drugs. Unqualified aides are reported to set up and pass medicines. It is said, charts are either not filled out as to medications given, or they are filled sporadically, some even filled days ahead of time. There are complaints of prescribed drugs not ordered; or ordered, charged to the client, and not given. There are allegations that patients are given other patients' drugs, sometimes inadvertently and sometimes intentionally. Persons are said to receive overdoses and underdoses of prescribed drugs. Employees report that medicine cabinets are not kept locked and medicines, even narcotics, prescribed for patients who have moved or died are kept, making up the homes' private pharmacy.

Finally, there are complaints received as to the administration and management of the nursing home and patient finances. Welfare patients are supposed to receive a minimal sum for personal spending each month from their welfare allotment. A public guardian—conservator from Sedgwick County writes: "There are many abuses in the present system, however, one of the greatest in my opinion is what is required to be paid from our clients' personal funds * * * . Many of the homes are adding charges for laundry and drugs (even though it's included in the per diem rate) and the like." Sometimes, it is reported that the welfare client is never credited with this personal spending allotment at all. Private patients complain that their personal funds are mingled with the home's funds or even lost. The law requires a ledger sheet to be kept on disbursements from a patient's personal funds, but it is alleged these often are not kept correctly. Even if a patient is correctly charged for personal items, it is alleged he or she often does not receive such.

All of the above are major areas in which the attorney general received complaints about the nursing home industry in Kansas. It was not feasible for the attorney general to extensively investigate all areas of complaints. De-

tails of the on-the-spot investigations which follow substantiate some of the claims. The investigation also showed, happily, that not all nursing homes are managed as those for which complaints were received. However, significant problems and deviations from statutory standards are revealed sufficient to cause further concern.

Investigation—Supervision of Department of Social and Rehabilitation Services and Health and Environment

The segment of the attorney general's investigation of the Kansas nursing home industry involved ascertaining who is responsible for supervision of nursing homes, and what standards do they apply. It was found that although many laws bear directly upon nursing homes such as the Kansas Pure Food and Drug Act, and both Federal and State Fire Safety Codes, the two main supervisors of Kansas nursing homes are the Department of Social and Rehabilitation Services and the Department of Health and Environment. The system Kansas developed has split the responsibility for nursing homes in such a manner that neither agency effectively supervises the overall treatment of nursing home residents.

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

The relationship of the Department of Social and Rehabilitation Services to the Kansas nursing home industry exists by virtue of the fact that it, as the receiving State agency, is vested with the responsibility of dispensing those Federal moneys received pursuant to the Federal medicaid program. In order for Kansas nursing homes to receive medicaid payments, Kansas had to develop a program to satisfy Federal guidelines as to supervision, administration, and disbursement of funds. Approval is conditioned upon whether the proposed plan sufficiently incorporates the Federal guidelines as found in 45 Code of Federal Regulation 249.12 et seq., authorized by establishment of the medicaid program in 42 United States Code 139a (a) (5) (1974). The plan for Kansas was federally approved and has been embodied by enactment of Kansas Administrative Regulation 30–10–1, et seq.

In administering the Federal program, the Department of Social and Rehabilitation Services is supposed to supervise standards in nursing homes in which medicaid recipients reside, to assure their maintenance to a certain standard. However, this department has no staff to inspect nursing homes and so accepts certification by the Department of Health and Environment as sufficient. The Department of Social and Rehabilitation Services does, however, have responsibility for auditing nursing home accounts to assure that personal allowances of medicaid patients are handled separately, and that medicaid funds sent directly to the recipients' nursing home are distributed and used properly.

Over 50 percent of the 22,000 plus nursing home residents in Kansas receive medicaid which is supposed to pay all or substantially all expenses. The remaining residents are private paying residents. The Department of Social and Rehabilitation Services is only responsible for auditing welfare recipients' accounts. Although, in theory, the Department of Health and Environment is responsible for checking the accounts of private paying patients not eligible for medicaid, no auditors whatsoever are deployed for such a task.

The method usually used by the Department of Social and Rehabilitation Services is to compare all "form 4's" (nursing home statements of cost for each welfare patient from which medicaid reimburses the home) to certain norms set by all homes' costs per patient. This is called a "desk audit." All "form 4's" are also supposed to agree with the homes' tax returns, however, the Department does not know to what extent it can go to obtain tax returns, therefore, this method is rarely used.

Homes that are out of line according to the norms when desk audited, are supposed to receive a "field audit." In a field audit, the auditor goes into the nursing home, checking its books and records of recipients and disbursements to see that they are in order. However, until August, 1975, the Department of Social and Rehabilitation Services had only one auditor to cover all 367 Kansas nursing homes. Therefore, field auditing has been done on a very limited basis, and was only concerned with funds of medicaid patients. Just

three homes have been audited in the field as of this date. No one is responsible to see that private patients' funds are not misused. There has never been a check of residents' personal fund accounts.

The Department of Social and Rehabilitation Services also cited as a problem, the fact that nursing homes complain of having trouble even covering costs with the funds medicaid provides, much less making any profit by having these patients. Evidence obtained by the attorney general's staff shows in many instances that actual "total per patient day cost" substantially exceeds the "per patient day rate" allowed by the Department of Social and Rehabilitation Services. This has also been stated as a problem by the Kansas Nursing Home Association in a resolution sent to the attorney general, dated August 21, 1975, in which it was urged in part:

"2. That the attorney general include in his investigation the actions of State agencies which tend to create two different systems in Kansas for nursing home care—one for the aged receiving public assistance and another for those funding their own care; and

"3. That the attorney general investigate the actions of the agency of the secretary of social and rehabilitation services which tend to impede and frustrate improvement of care for the aged when it refuses to allow payment of reasonable charges for half of all persons receiving care and seeks to cast the entire burden of improvement of the quality of care upon the private paying infirm aged persons in Kansas, and when the Kansas Legislature has diligently sought to assure that the public policy of Kansas would be that the distinction should be made either in the quality of care or burdens of payment by the aged; and * * * ."

The result is that private patients in Kansas nursing homes are usually charged more for their care than are welfare patients to make up the difference. Private patients, in effect, are subsidizing welfare patients. There is also undocumented testimony that relatives of welfare patients, in order to get the welfare recipient admitted to nursing homes, are forced to pay extra money in secret to the administrator each month. This too, is deserving of further investigation.

THE DEPARTMENT OF HEALTH AND ENVIRONMENT

Licensing of nursing homes in Kansas has long been a function of what is now the Department of Health and Environment. Kansas Statutes Annotated 39-923 et seq., defines adult care homes and gives the Department of Health and Environment both licensing and continuing supervisory powers over them. The Department of Health and Environment, in Kansas Administrative Regulations 28-38-1, et seq., sets out extensive and detailed requirements for adult care homes. These regulations cover everything from qualifications and health requirements for employees and fire safety requirements, to requirements for a bedfast resident to have a pitcher and a cup of water beside his bed and a window sufficiently low that he may see outside. In addition to preliminary licensing inspections, the Department of Health and Environment is authorized to make unannounced inspections at any time deemed necessary.

Although the Department of Health and Environment is given extensive powers to supervise nursing homes, in truth, these powers have proven effective only on paper. There are, at this time, 367 nursing homes in Kansas, having a total population of over 23,000 beds with approximately 95 percent occupancy. For purposes of inspection of these homes plus any new establishments seeking licenses, the Department has divided the State into six districts. One nurse is assigned to inspect all adult care homes in each district.

The attorney general's staff has reviewed many of the files kept by the department as to each nursing home. These files reveal results of inspections plus any private complaints sent to the department. Of the 50 files studied. 30 cited fire safety violations, 10 of these having over 10 violations. There were cited 9 instances of drugs and medications improperly handled, 9 instances of incomplete patient charts and records, 8 mentions of dirty rooms or rooms smelling of urine, and several mentioning various other illegalities such as aides dispensing medicine, bad food quality, employees without medical exams, et cetera. These were the results of inspections which, according to several complaints received from nursing home employees, are known to be coming at least a week before they take place. That these forewarned and necessarily

superficial inspections turn up only the most obvious illegalities in the physical plant of a home, and totally neglect aspects of patient care and home administration, is made obvious by the results of sufficiently manned surprise inspections made by the attorney general's staff.

The violations which are discovered and cited in an inspection report may very well be there again in the next year's report. Although the department has regulations for most aspects of nursing home structures and administration, it has very little power to enforce these. If violations are sufficient, the department may take away a nursing home's license, but this is appealable first to the department and then de novo through the court system. It is rare for the courts to uphold revocation of a license partly because the department has neither the staff nor the expertise to prepare all the evidence against an administrator. This is evidenced to a degree by an admission in a letter received by the attorney general's office written July 7, 1975, in which Dr. James D. Mankin, acting director of health, states:

"The Department of Health and Environment requests that the office of the attorney general conduct an investigation to ascertain if Mr. ------ is of good moral character and suitable to be relicensed as an administrator. *The department does not have the staff or expertise to conduct an investigation of this type and we trust you will comply with our urgent request.*"

[Emphasis supplied.]

Therefore, only in extreme cases, obvious even upon superficial examination of the condition of the home, are violations provided against.

What happens in actuality to nursing homes is that, after a preliminary inspection for licensing purposes, and with periodic cursory inspections primarily for fire safety violations thereafter, a nursing home is certified as such by the Department of Health and Environment. Then it becomes the concern of the Department of Social and Rehabilitation Services, which supervises certain standards of nursing homes in which recipients of medicaid or other welfare benefits reside.

After studying the bifurcated system of nursing home supervision in Kansas, it is obvious why violations of regulations can go unobserved or unpunished in Kansas nursing homes. Each department is understaffed and feels it is the responsibility of the other department to supervise all but the most superficial aspects of the nursing home industry. The result is that only these most superficial aspects are inspected, and it is almost entirely up to the nursing home administrator what quality of establishment he wishes to run.

Investigation—A Physical Inspection of the Homes

On August 11 and 12, 1975, a team from the attorney general's office of the Consumer Protection Division, consisting of an accountant, a registered nurse, two attorneys, one secretary, two investigators, and a legal assistant made unannounced visits to nursing homes in Salina, Wichita, and Topeka, Kans. Because of a limitation of funds, this team could not investigate more homes in different locations throughout the State. The attorney general had requested members of the Department of Health and Environment, as the licensing agency normally responsible to check these homes, to accompany this investigative team and aid in the inspection. The department refused to send anyone to help with the inspections unless provided with a list of specific nursing homes to be inspected, at least a week before they were to be visited. As the attorney general had received complaints that nursing homes were forewarned of the Department of Health and Environment's inspections at least a week before they occurred, it was not considered consistent with the purpose of this investigation to provide the department with the information they sought. Therefore, no one from the Department of Health and Environment accompanied the consumer protection investigative team.

Upon entering a nursing home, each person had a checklist of specific things to look for. The registered nurse and one investigator first checked to see the existence and maintenance of a nursing care plan for each resident. They then picked at random four patients to investigate more thoroughly. In addition, they made spot checks of the general facilities, checking for specific violations, and asked questions of nurses and aides as to conditions of patient care. The accountant and the secretary asked for accounting records, which were uniformly unavailable to him. He then checked available

records of patients' personal funds, qualifications of administrators and employees' health certificates. One attorney and a legal assistant checked the homes' compliance with general areas of laws, rules and regulations, and one attorney was responsible to oversee the efficiency and legality of the total investigative efforts.

ACCOUNTING

The first area of this report concerns the accounting records. Before the actual inspection of nursing homes began, the attorney general was notified of an instance in which the administrator absconded with an extremely large check to the home for care of medicaid patients. The accounting records were taken to a private firm for audit, however, they were so sparse as to be violative of legal regulations. There was evidence that the administrator had written checks other than payroll checks to himself from those funds previously, and that some private patients' checks were not deposited in the nursing home account in violation of State regulation and Federal law. The patients' accounts were inadequate and in some cases, missing. In addition, there is evidence that the administrator had, sometime previously, been known to have violated at least two regulations, violations of which were grounds for revocation of his license. Members of the Department of Health and Environment were present for this inspection, but claimed their main concern was to see the patients were cared for and that funds of the State or Federal government were the responsibility of the Department of Social and Rehabilitative Services.

In the eight other homes investigated, the regular accounts were all unavailable to the investigative team. However, the accountant was able to check how the home managed patients' personal funds in all of the establishments. It is required that, if a nursing home has authority to handle a patient's personal fund, they be clearly separated from general funds with all receipts and disbursements recorded. It is customary to either have an envelope containing the money with a record of receipts and disbursements, or a trust bank account. Four nursing homes had adequate records and management of residence's personal funds. One home's records were nearly adequate, with an envelope containing the residence's money having only records of disbursements. In one home, separate trust bank accounts are maintained. However, there was a discrepancy in the balance shown. The balance per individual ledger card was $3,817.93, however, the checkbook reflected a balance of $1,991.33 and the bookkeeper stated she had approximately $80 in cash. There was also a suspicion raised in the accountant's mind because it appeared that all entries in the patient's personal fund accounts were made with the same pen, in the same handwriting with very little variance in handwriting. Different dates were shown, however, for the entries. One home had an inadequate method with ledger cards showing balances in 16 residents' accounts, but there were no separate bank accounts. The residents had signed forms allowing the administrator to disburse their funds. Another home had individual trust bank accounts for all patients. The balance per ledger card was $2,120.29, however, where the bank account showed a balance of $6,515.94. There was a $6,000 check written on the account and then redeposited later, which the accountant found suspicious. The over balance in the account may indicate the home is not refunding money when required. In this home, patients' individual accounts were charged for talcum powder, hospital gowns, and other questionable items.

In checking administrators' qualifications, it appears that all administrators were statutorily qualified to run a nursing home. However, no home had health certificates for all employees as required by regulation. The better homes had certificates for all employees except those hired within the last 2 or 3 months, however, this is still a violation. In one home, 25 of 38 employees had no health certificates and in another 12 of 21 employees were in violation.

Several of the nursing home owners complained to the accountant that medicaid reimbursements for costs of welfare patients were insufficient to cover the cost of caring for those residents. One owner, who was putting in a sprinkler system required by law at the cost of $45,000, said he could only operate at a profit with 33 to 38 percent welfare patients and the rest private patients. At this home, private rates are $14.50 per day while welfare rates at level one are $15.13 per day and level two, $12.98 per day. Several of the

homes studied showed differences of a little over $1 per day in the average welfare reimbursement and the private patient rates.

Turning the compliance with general regulations concerning nursing homes, it was found the homes were generally lacking in at least two areas. In the first, both Federal and State regulations require that written policies and procedures governing all areas of service provided by the facility be made available to staff, residents, and the public. From these policies and procedure statements, residents should know their legal rights and residents and staff should be told of a method for registration and disposition of complaints without threat of discharge or reprisal. While most homes investigated had formed such policies, although two homes could not produce such upon request, in none were they readily available to the staff and residents. If available, the policies were not compiled in one booklet. This made it questionable, although it was impossible for this inspection to determine whether there is an in-house education process where employees are informed of their duties and taught current methods of fulfilling patient needs.

The other area of concern was compliance with the Fire Life and Safety Code. A home has, under Federal and State requirements, up to 2 years to bring its physical plant into compliance with new safety standards. Therefore, sprinkler systems, et cetera, may not be present in a home without comprising an actionable violation at the present time. However, health and environment records had revealed the presence of many fire violations in a sizeable number of nursing homes. One violation particularly disturbing to the investigation team occurred in a Topeka nursing home. The fire exits at either end of a long hallway off of which lived many handicapped patients were tied shut with a wire and a sheet. The doors were tied to handrails running along the sides of the hall, and were so securely fastened that the investigator could not force the door open wide enough for even one person to squeeze through. Another potential hazard found, which specifically violates a requirement for nursing home licensure, was that an oxygen tank was left in a unlocked closet in the home. Oxygen is a highly volatile substance subject to explosion which is required to be stored in an enclosed inaccessible area outside of the nursing home proper.

DRUGS AND MEDICATIONS

The requirements as to storing and dispensing of drugs, particularly narcotics, were another area of investigation. It was found that all of the homes kept the medication cabinet or room locked as required. However, only four kept all narcotics in a locked compartment or container in the locked room, as required. It appeared that several drugs, even in homes where narcotics were segregated, were not recognized by the person in charge as being narcotics, and so these were left out.

The requirements as to dispensing narcotics were found to be violated in some manner in every home inspected. Every nursing home had incomplete records. The shifts often failed to sign the record when medication was or was not dispensed. A nurse must count the number of pills when administering narcotics. Often the records did not show a count, or there were miscounts found when the investigator checked the number of pills and found it did not agree with the record. Miscounts were found in every home, but there were no records in six of the homes of any narcotics dropped on the floor or lost or wasted some other way. The nurse investigating found evidence of nurses or aides borrowing narcotics from one resident for another for whom it was not prescribed.

It is required that narcotics be destroyed upon a resident's death. In two homes, narcotics were found belonging to persons who had died as much as a month before.

PHARMACIES

A final area of concern for this phase of the investigation was the relationship of pharmacies to nursing homes. In one home, the controlling interest was found to be owned by a local pharmacist. Upon talking to one patient in that home, it was discovered that this patient had been billed by that pharmacist three times for each of two separate drugs in a 3-week period. Normally, a prescription of each of these drugs lasts for a 3-week period. This same pharmacist is shown to be the only pharmacist filling prescriptions for residents of another nursing home in the same city and the primary pharmacist

for a third. These facts certainly warrant further investigation. In several other nursing homes, the drugs come almost entirely from one pharmacy. Each home stated, however, that the patient was free to purchase the drugs elsewhere if desired. Of course, many of the patients are bedridden. The Federal investigation of nursing homes has shown where a sufficient volume in drug sales to one pharmacist, a strong possibility of illegal kickbacks to the pharmacy exists. The situations above-mentioned are certainly worthy of further investigation.

The final portion of this report deals with results of inspections by the registered nurse and investigator into the quality of resident care, nursing care and use of medication and physical facilities within the nursing homes.

Although in some homes, residents were found to be kept free of odor, two homes were in violation of these requirements in the strictest sense. In one of these homes, the bed patients had a very strong urine odor and in the other, the smell of urine was so intense that it had permeated the entire building to include the dining area and kitchen facilities. In this home, patients were dirty and smelled of urine and body odor. The nurse's records evidence of odor in all but three homes visited.

There were bed patients found to be wet and had not been given partial baths. This seemed to be a common violation in one of the homes, while in another home, the personal clothing of residents did not appear to be laundered as is required for the health, grooming, and well-being of the resident.

Restraint of patients were checked and seemed to be used correctly. No evidence was found to substantiate claims of misuse of jackets, sheets, cuffs, belts, etc. In the same light, however, one of the homes had absolutely no activities planned to meet the requirements for socialization of patients.

All homes checked provided drinking fountains accessible to the residents. However, for those nonambulatory patients having to rely on a pitcher of water to be placed bedside (as per regulation), two of the homes were noncompliant. In three homes, the pitchers did not appear to be washed and sanitized daily as required.

Supplies required for personal hygiene was an area of considerable alarm. Violations were widespread. Four homes did not provide each resident with soap and a soap dish. Most of these provided a community bar of soap which, on more than one occasion, was found on a dirty floor. One home did not provide adequate tooth and denture cleansing equipment, nor denture cups for patients requiring such. Four of the homes failed to provide the residents with combs and/or brushes, nor did they have adequate washcloths, hand towels, or bath towels. In most homes, there were not enough towels to go around and in one, the washcloths and towels were rags.

NURSING CARE AND MEDICATION

Regulations require that several record systems be kept to record medications, treatments, physicians' orders, and the continuing conditions of the residents. It is considered to be extremely important for all such records to be kept current, accurate, and signed by the physician. It is imperative that nurses note records accurately, up-to-date information of the care, medication, and treatment afforded the resident by the nurse. Deviation from such practices make accurate evaluation by the doctors impossible and therefore, mistaken medication can be prescribed, etc.

The homes checked as to their recordkeeping procedures in these areas were found to be generally sloppy, inaccurate, and negligent. There were 32 to 46 violations found. Unfortunately, these figures are miniscule, when it is realized that only 5 to 10 percent of all patients were spot checked.

A violation common to all homes was that some orders for medication, care, and treatment were not signed by the physician. In over half of the homes, the nursing care plan was not accurate or up-to-date. In one home, a resident had been hospitalized for almost a week without mention in the plan, while in another, a drug had been prescribed with no evidence of it being dispensed to the patient. The patient was also a diabetic and the last recorded FBS was in October of 1973.

Communications between home and doctor seemed lacking. Regulations require that a physician order sheet be kept. In half of the homes, the

physicians' orders for medication and treatment were not always signed by the physician.

All prescribed medicines are required to have prescription numbers, dates, pharmacy name, directions for taking, et cetera. In two of the homes (or 25 percent), loose pills were found in the medicine cabinet.

Orders to stop medication and instructions for disposition of medicines are required to be written on the physicians' order sheet. One home was found to have outdated insulin in the refrigerator while as was stated earlier, drugs were found to be kept on hand after the resident's death.

Medications are to be dispensed as instructed by the physician and by trained personnel. In two of the homes, prescribed medicines had not been dispensed when checked 2 hours after the prescribed time. Also in two of the homes, untrained aides were seen to be dispensing medication.

In many of the homes, plastic medicine dispensing vials were being washed and re-used. There was no attempt to sterilize these. This is not in violation of any specific regulation, but is in violation of sound medical practice.

Generally, the key to the medicine cabinet is kept by the nurse on duty who is responsible and assigned to dispense the medicines. In two homes, however, the key to the medicine cabinet was kept at the desk.

Homes are required to keep disinfectants, bleaches, rubbing alcohol, and poisons in a separate locked compartment apart from medications. Seventy-five percent of the homes checked were in violation of these regulations. Of these in violation, all of the aforementioned supplies were available to anyone.

The nursing notes were in poor condition and in violation of the regulations in half of the homes visited. The notes were not current, or if found current, treatment or medication had not been given as ordered. In one home, there was no record of a catheter change for a period of 1 month. Staff, when questioned, could not say for sure when the catheter had been changed.

Medications are required by law to be kept separate as to individual residents. In one home, medication for two residents were found commingled and in another instance, medication for one patient was found left on the bedside of another patient. The clinical records which are required to be kept appeared to be satisfactory.

A look at the total picture as to nursing care and medications found by the investigating team seemed to indicate a rating of very poor in four of the eight homes, or 50 percent, and only fair in the others. These conditions could most probably have led to many persons getting mistaken medication or treatment ordered by the physician.

FURNISHINGS AND FACILITIES

It was found generally in the bedrooms of the homes visited that bed screens or curtains were provided for privacy. It was found, however, in one home that no curtains were provided for several of the rooms. In four of the homes, there were few to no extra pillows provided in case of patient discomfort.

Only three of the eight homes had a sufficient supply of sheets and pillow cases to keep the beds clean, dry, and free of odor. In four of the eight homes, extra linen was very sparse and worn. In one home, there was no extra linen in the linen closet. Only three of the eight homes had sufficient lightweight blankets to assure the warmth of each resident. There were no extra blankets in four of the homes, and in one home there was not even enough to go around.

Only three of the eight homes had a wash cloth, hand towel, and a bath towel for each resident. In five of the homes, there were very few washcloths, and those were rags or very worn at best. In five of the homes, there were absolutely no hand towels and no more than one bath towel accessible to the patient. Clean towels were many times not acceptable to the residents. Of those rooms checked, there were between 10 and 23 violations regarding furnishings of the rooms.

Of the homes checked, the food service facilities as well as the nursing, dining, and recreation facilities were generally adequate. However, the toilet and bath facilities were subject to three violation citations in three of the homes visited.

In one home, the toilet stools, bathtubs, or showers were not all equipped with continuous metal handrails and/or grab bars. In one home, there were no rubber mats for the bathtubs and showers. In another home, the facilities were very dirty and it appeared that one bathroom was used by both men and women residents, while the other bathroom was used for storage.

FOOD HANDLING

Two of the eight homes visited were found to be unsatisfactory as to the handling of food. Outer garmets worn by the food handlers were dirty and in one home, the dietician had dirty fingernails, while in the others they wore no hairnets. These are in violation of the regulations.

Basic nutritional needs of the residents seemed generally to be adequate. However 75 percent of the homes visited did not post a menu so that the residents could see them, and although all persons had three meals a day, 50 percent of the homes had more than 14 hours between breakfast and supper.

EXTRA REQUIREMENTS FOR SKILLED NURSING CARE

In-service educational programs were not checked, but in all homes, the nursing care was under the immediate supervision of a registered nurse. The homes had the minimum equipment required for skilled nursing care. However, in two homes, washbasins could not be found and in one home, there were both rectal and oral thermometers as required, but were not marked "clean" or "dirty."

Homes are required to be constantly under the immediate supervision of a registered nurse licensed to practice in Kansas. In one home, there was no registered nurse on duty.

There were physical and occupational therapy rooms, but 50 percent used them for storage rather than therapy.

Conclusion and Legislative Proposals

The purpose of the investigation and this report is to advise the attorney general on matters relating to the care and appurtenants thereto of the institutionalized elderly of the State of Kansas. The conclusions drawn from this study coupled with Federal findings and proposed legislative reforms will hopefully assist him to recommend general guidelines to responsible parties in position to act accordingly. The demand for Federal and State reform is imperative and urgent.

It should be noted that this study established time and again that those findings of the Subcommittee on Long Term Care of the Special Committee on Aging of the U.S. Senate were not foreign to the State of Kansas. Once this is realized, it should be noted that without question other findings of the subcommittee not in this report, are a distinct and real possibility in our State. Therefore, attached and made a part hereto are condensed findings of the subcommittee indicating the major points as set forth in their supporting papers. These points, as attached, were found specifically in supporting paper No. 3, "Doctors in Nursing Homes: The Shunned Responsibility," although each of the papers made note of such.

Any conclusions drawn from this report or proposals given credance therefrom would necessarily find several points to be most particular and conspicuous as to their inadequacies in Kansas care for the institutionalized elderly. These would include but not limit themselves to the following:

(1) The conditions found in many nursing homes of Kansas do not conform to those required by law and agency regulations which would seem to expose the need for more efficient enforcement procedures.

(2) Present law and regulations are not sufficient to protect the mental and physical health of the approximately 20,000 Kansas citizens residing in nursing homes.

(3) The nursing home system in the State of Kansas is governed in its various areas by splitting the responsibility primarily between two agencies and, to a certain extent, several others. Such bifurcations and over lapping of jurisdictions and duties is responsible in part for the ineffective supervision of overall treatment of nursing home residents and control of public as well as private funds.

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(4) No one agency has the power, expertise, or staffing to effectively regulate, oversee, or evaluate the nursing home industry in the State of Kansas today. Violations of laws and regulations go unobserved or unpunished, and in most cases, observance of many laws by administrators and the quality of the establishment he runs is entirely up to him.

It would seem that laws and regulations governing the nursing home industry in Kansas are in urgent need of reform. Federal changes are being proposed and bills introduced at an ever increasing rate as national concern mounts. "A model act for the regulation of long-term health care facilities" has the unofficial endorsement of the Subcommittee on Long-Term Care and has been used extensively as a guideline for many progressive nursing home industry proposals on the Federal and State levels. A copy of the "act" is attached and made a part of this report.* Other recommendations by this office, particularly dealing with the needs of the State of Kansas, would include bills which would provide for:

(1) Requiring public ownership disclosure of any nursing home ownership, including real estate and operating interests;

(2) Requiring the disclosure of nursing home suppliers;

(3) Requiring public accountability by nursing homes;

(4) Encouraging training in geriatrics and special training for nurses, aides, orderlies, et cetera, in the needs of nursing home patients;

(5) Requiring the posting of a nursing home's license, medicare/medicaid certification, a description of the services provided by the facility, a list of the owners and staff of the facility, a patient's bill of right and other pertinent information;

(6) Requiring nursing homes participating in Federal programs to file CPA audited cost and financial statements and to provide penalties for fraud or misrepresentation;

(7) Requiring of inspections of nursing homes at least every 180 days and to require enforcement of the rights of patients in such facilities;

(8) Requiring ombudsman programs to investigate nursing home complaints;

(9) Requiring strict controls for the handling of patients' accounts and personal expense funds;

(10) Making it unlawful to solicit or receive charges to a medicaid receipi-
ed and solicitation or receipt of any
n as a precondition of admittance to

r surveyors inspecting nursing

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